HEALTH CARE AT A CROSSROADS: MEDICAL TOURISM AND THE DISMANTLING OF COSTA RICAN EXCEPTIONALISM

by

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ABSTRACT
Based on a year of ethnographic fieldwork, this dissertation explores the development of the global medical tourism industry in Costa Rica and the social, ethical, and ideological implications that its growth may have for the existing socialized health care system. This study seeks to understand the ways in which medical tourism, as a model of global neoliberal health care, affects how Costa Ricans think about delivery of and state responsibility for health care. The research draws deeply on the social, economic, political, and cultural contexts in which medical tourism is unfolding. It addresses the ideological tensions and contradictions that surround medical tourism, as the line between conceptions of health care as local and global, socialist and capitalist, public and private, blurs to accommodate this emerging industry. Rather than emphasizing the view of medical tourism from the top, the focus is on local perceptions, understandings and engagements with medical tourism. Grounded in the experiences of Costa Rican health care providers, educators, policy makers and citizens, this paper tells the story of a system in flux.

The form and content of this abstract are approved. I recommend its publication.

Approved: Stephen Koester
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When I returned from my fieldwork, I sat down in Steve Koester’s office in a frenzy about the many snags I hit, and all the things that didn’t go as I had hoped. He patiently let me finish my exasperated rant, leaned back in his chair and said “I’m so happy to hear you say that!” When I looked at him a little funny, he clarified, “Well if you came back and told me that everything went smoothly and exactly as you planned it, that’s when I would have known that you didn’t really do the work.” This journey has not always been smooth—or even close to perfect—but I did do the work.
TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION
Research Questions ............................................................................................................. 3
Theoretical Approaches and Organization of Text ............................................................. 4
Research Methods ................................................................................................................. 6
  Research Assistant ........................................................................................................... 10
  Challenges to the Research ............................................................................................... 11
  Data Sources and Analysis ............................................................................................... 14
  Field sites .......................................................................................................................... 14
  Reflection on Fieldwork ................................................................................................... 15

CHAPTER 2: AN OVERVIEW OF THE GLOBAL MEDICAL TOURISM INDUSTRY
  From Individual to Industry: The Global Growth of Medical Tourism ........................... 18
  Defining Medical Tourism ............................................................................................... 18
  Changing Patterns of Medical Travel .............................................................................. 21
  The Procedures Medical Tourists Travel For .................................................................... 23
  Medical Tourism Destination Countries .......................................................................... 29
  The Current State of the Medical Tourism Industry ....................................................... 32
    Data Challenges and Questionable statistics .................................................................. 32
    Global Actors in the Medical Tourism Industry ............................................................... 34
  The Role of Governments in Destination Countries ...................................................... 41
  Global Impacts of Medical Tourism ................................................................................ 42
    The Potential Benefits of Medical Tourism for Destination Countries ....................... 44
    The Potential Harms of Medical Tourism for Destination Countries ........................... 45
  The Research Project ........................................................................................................ 48

CHAPTER 3: HEALTH WITHOUT WEALTH— THE COSTA RICAN CONTEXT
  Social Medicine in Latin America .................................................................................. 50
  Costa Rica as a Case Study .............................................................................................. 53
    Colonial History ............................................................................................................ 53
    Health System Successes ............................................................................................... 56
    History and Development of the Health System .............................................................. 59
    Medical Education and the Institutionalization of Medical Practice ............................... 62
  Quality of Care in the Caja ............................................................................................. 68
  Solidarity as Ideology: Principles of the Caja ................................................................. 70
  The Costa Rican Image and the Medical Tourism Blueprint ............................................ 72

CHAPTER 4: PRIVATIZATION OF THE HEALTH CARE SYSTEM
  The Relationship between the Public and Private Health Care Sectors ......................... 76
    The Role of the Private Sector in Health Care Provision ............................................... 77
    The Private Sector Today ............................................................................................... 81
  Internal Pressures on the Costa Rican Health Care System ........................................... 82
    Demographic Changes in Costa Rica .............................................................................. 82
    Threats to the Caja’s Financial Stability ......................................................................... 83
    Unnecessary Patient Referrals to the Caja ....................................................................... 86
    National Management of Human Resources ................................................................. 88
    The ‘Contrato de Aprendizaje’ ....................................................................................... 90
  Deteriorating Conditions in the Caja .............................................................................. 93
Working in Both Sectors ................................................................. 96
Passive Privatization..................................................................... 98

CHAPTER 5: NEOLIBERAL PRESSURES ON THE HEALTH CARE SYSTEM ......................................................... 101
The Principles of Neoliberalism ...................................................... 101
Impacts of Structural Adjustment Programs on Public Health .... 103
SAPs in Latin America ................................................................. 103
SAPs in Costa Rica ........................................................................ 105
Impacts of Trade Agreements on Public Health ......................... 108
The Central American Free Trade Agreement ......................... 111
Global Impacts of Neoliberalism .................................................. 117
Individual Impacts of Neoliberalism ............................................. 119
The Love—Hate Relationship with the State ............................... 125

CHAPTER 6: LOCAL EXPERIENCES OF MEDICAL TOURISM .......................................................... 127
National Actors and the Health Care Cluster ............................. 127
Emerging Industry Actors as Gatekeepers ................................. 131
Creating Special Spaces for Medical Tourists ............................ 134
The State of the Medical Tourism Industry in Costa Rica ......... 138
Local Hopes for Medical Tourism .............................................. 140
Local Anxieties about Medical Tourism ..................................... 143
Competition .............................................................................. 143
Capacity ................................................................................... 147
Medical Tourism Development in Guanacaste .......................... 148
Medical Tourism and Inequities in Costa Rica ....................... 150
Financial Resources ................................................................. 151
Internal Brain Drain .................................................................. 153

CHAPTER 7: MEDICAL TOURISM AND COSTA RICA’S CONTRADICTING VISIONS ........................................ 159
Costa Rica’s Contradictions ....................................................... 159
Medical Tourism and Opposing Ideological Values ................. 160
Competing Visions of Health Nationalism ............................... 163
Medical Tourism Under a Social System ................................. 166
Medical Tourism, Distributive Justice and Moral Pluralism ....... 168
The Shifting Role of Social Responsibility ............................... 172
Regulating Medical Tourism ...................................................... 175

CONCLUSION ............................................................................. 178
WORKS CITED ........................................................................... 181
APPENDIX A: EXAMPLE INTERVIEW GUIDE .......................................................... 196
APPENDIX B: SURVEY GUIDE ......................................................... 201
APPENDIX C: PARTICIPANT LIST ....................................................... 205
LIST OF FIGURES

Figure 1: Break down of interview participants by primary profession .................... 8
Figure 2: Break down of physicians interviewed by employment sector .................. 9
Figure 3: Medical tourism ads featuring beaches and other tourist attractions ......... 20
Figure 4: Map of popular medical tourism destinations ......................................... 29
Figure 5: Bumrungrad Hospital lobby and a patient room ..................................... 31
Figure 6: A medical tourism blogger shows that Bumrungrad Hospital in Thailand is “U.S. Approved!” ................................................................. 36
Figure 7: A model of the global medical tourism industry ..................................... 41
Figure 8: Slogan of the Costa Rican Tourism Board: “Aquí se cura todo” (Here we cure all) ............................................................................................................. 73
Figure 9: Idyllic images of Costa Rica: waterfalls, volcanoes and beaches .............. 74
Figure 10: Hospital San Juan de Dios, and an EBAIS primary care clinic ............... 96
Figure 11: Election Day, February 2010. Costa Ricans supporting their candidates ... 112
Figure 12: Resistance to CAFTA/TLC ................................................................. 116
Figure 13: The Costa Rican health care cluster ...................................................... 129
Figure 14: The role of the government in supporting the medical tourism industry ... 130
Figure 15: The special spaces of medical tourists .................................................. 137
LIST OF TABLES
Table 1: Cost comparison of medical tourism procedures by country ............................. 24
Table 2: Common surgical treatments promoted by medical tourism agencies ............... 28
Table 3: Health and equity indicators for Costa Rica, the United States, and Mexico..... 58
<table>
<thead>
<tr>
<th>ACRONYMS</th>
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CHAPTER 1: INTRODUCTION

Very early one morning, I head out of my San Pedro apartment building to begin my trek up the steep neighborhood hill to the main road to catch my almost daily 40-cent bus ride into the city. Miguel, the guard to my building—which also is gated and surrounded by wrought iron bars—does not like that I am out while it still dark; he reminds me again this morning to be careful. But I have an 8am appointment at CIMA Hospital, in the suburb of Escazu, which will take me a long time to get to by bus.

At the top of the hill, I brace myself for my daily peril—a sprint across four lanes of speeding traffic, interrupted by a quick climb over a median, and then another dash across two more lanes of traffic. I arrive in one piece today, out of breath, and swiftly board my bus.

When I reach the city, San José is just starting to come to life. Fruit sellers are out on the corners, shop owners raise their bars, business people make their way into office buildings, and illegal street vendors lay out tarps to display the various pirated movies and cheap goods they will try to sell today.

To catch my next bus, I must walk about a mile through the center of San José to the Coca Cola bus terminal on the west end of the city. The area around the terminal is crowded and dirty, and I often must step into the street to maneuver around busy commuters, beggars, and trash that obstructs the sidewalk. This is a dangerous proposition, as a never-ending line of swerving, honking cars tries to make its way through the congested area as well. This district is particularly known as being unsafe, especially for tourists; I keep my head down and walk briskly to my bus stop, trying to go unnoticed. I am mostly successful, though I do hear a couple of “Hola macha!” [Hey blondie!] shouts, followed by the characteristic lip-smacking sound that accompanies such a shout.

As the bus makes its way out of San José and into Escazu, I am struck by shifting landscape, as the dirty, narrow, crowded streets of San José give way to an expansive highway surrounded by lush green hills. This is my first time visiting Escazu, though I have been told that it is where all of the American expatriates live, and that there is a large upscale mall here where I could go if I wanted “American things.”

I think of my earlier street-crossing adventure as the bus pulls up to a raised walkway, which valiantly traverses the highway below, and leaves me standing in front of the CIMA Hospital complex. It is positively gleaming in the bright morning sun, which reflects off of the modern glass façade, giving it a truly radiant appearance. Even though I am early, upon entry, I am greeted by a uniformed attendant, who takes me directly to Ophelia, the international patient coordinator, who would be happy to give me a tour of the complex before she escorts me to the office of the physician whom I will speak with.
This is a sharp contrast to my experience just one day earlier at a public hospital, San Juan de Dios in downtown San José. I arrived early then, as well, but spent about 15 minutes roaming through a maze of unmarked hallways asking hurried nurses where I might find the particular doctor I was looking for. After three failed attempts at finding him, a sympathetic nurse finally sat me down on an orange plastic chair in a narrow hallway and told me to “just wait.”

I was seated in front of a giant laundry bin that contained an absolutely enormous pile of scrubs. Hospital staff rushed through my little area, grabbing mismatched pairs of wrinkled scrubs from the bin, and then quickly hurried off again. Unconscious patients were wheeled by on gurneys; a nurse walked by carrying vials of blood; in an adjacent room, a child cried loudly as he received a shot, in full view of the packed waiting area.

The doctor who I am meeting arrives to retrieve me 35 minutes after our scheduled appointment. “Sorry, I had to check on patients,” he apologizes, as he ushers me into a cluttered room lined with mismatched communal desks, where at least five others are working. “Welcome to my “office,” he laughs, holding his hands out, while we search for an available area to talk. “I have to check in for surgery in 20 minutes,” he says, “so we should get started.”

—Adapted from field notes February 25th and 26th, 2010

These marked differences between public and private spaces of health care consumption are indicative of the mounting contradictions of the national political project in Costa Rica. A divergence is occurring, as past visions of health care—based on social solidarity and state-sponsored medicine—give way to future visions of health care based on privatization and global wealth accumulation. The emerging practice of medical tourism, which takes place within new private spaces like CIMA, is illustrative of the ideological shift that is currently underway in Costa Rica. Though it is entrenched in larger political and economic forces, many of which are external to Costa Rica, the way that Costa Rica incorporates medical tourism into the national political project is colored by the nation’s successful social health care system.

This dissertation explores medical tourism within the particular context of the Costa Rican health system. As a novel configuration of health care provision in an
increasingly global world, this practice of crossing borders for health care facilitates new ideological encounters, as national systems of health care collide with the global health care economy. Within Costa Rica, this clash occurs between a national health care model based on principles of social medicine, and a model of neoliberal health care that continues to spread, despite its failings within the developed nations of the world. Costa Rica’s historical orientation towards public health care provision, positioned alongside the neoliberal model of medical tourism, provides fertile terrain for analyzing the paradoxes of globalization. This research attempts to make visible the contradictions of this practice, through “following the fault lines out” (Nordstrom 2007). This study began in the United States with research in, and on, the medical tourism industry and followed the connections to Costa Rica, a very popular medical tourism destination for Americans.

To date, there is little scholarly research on the effects of medical tourism in destination countries. Though recent academic studies have begun to examine the topic more critically, there are very few firsthand accounts that assess the impacts of medical tourism within a particular context. This research takes a step towards filling this gap by critically engaging with the practice of medical tourism, and its situation within larger power relations, in the Costa Rican context.

Research Questions

This research set out to answer the overarching research question: *How does medical tourism impact health care in Costa Rica?* To do this, it focused on the following five sub-questions:

(RQ1) How is the medical tourism industry integrated within the state-dominated Costa Rican health system?
(RQ2) What are the differences- organizationally, structurally, and with regard to patient population- between public hospitals that serve
mainly local and poorer populations and private hospitals that serve medical tourists and wealthier Costa Ricans?

(RQ3) Where do the profits from the medical tourism industry go?

(RQ4) Does medical tourism draw resources and physicians away from public health care?

(RQ5) How does medical tourism impact the way that Costa Ricans think about health care?

Theoretical Approaches and Organization of Text

Anthropology, with its sensitivity to the actors’ point of view and the ways these contradict or clash, combined with its capacity for problematizing the taken for granted …is particularly suited to analyzing how ideologies infiltrate the institutions of practices of everyday life. (Shore and Wright 1997)

To draw connections between global industry and local health care in Costa Rica, I utilize critical anthropological perspectives that enable a shift of scope from macro to micro-processes and back again. In particular, this research offers a political economy of the medical tourism industry.

Political economy of health perspectives are particularly adept at examining the complex and nuanced problems of globalization, and the processes by which individual lives and local communities are affected by political, economic and cultural forces that operate worldwide (Appadurai 1991). These perspectives are concerned, as this project is, with the distribution of global resources and how global power structures influence health. Rather than creating a separate section to discuss theory as it relates to the study of medical tourism, theoretical perspectives are incorporated throughout the dissertation, connected to the particular themes of each chapter.

In Chapter One, I discuss the changing patterns of global medical travel, offer an overview of the medical tourism industry, and analyze the various arguments both for and against medical tourism within the existing literature. The fundamental assumptions of the industry, rooted in neoliberal principles, are introduced in this chapter. I argue here
that the medical tourism industry has developed a “blueprint” for destination countries, that lays out specific criteria for what comprises a good destination, and the careful lines that participating nations must toe in order to participate.

In Chapter Two, the lens is shifted to the specific context of Costa Rica, and I trace the development of social medicine here and discuss its role in health nationalism. Costa Rica has had notable successes in health care indicators, uncharacteristic of a developing nation with such a small GDP. However, the way that Costa Rica has come to fit the “blueprint” for the medical tourism industry—through a public system based on solidarity, equity, and universal coverage—is in sharp contrast to the underlying principles that medical tourism represents. Ironically, it is the successes of its social system that have allowed Costa Rica to emerge as a medical tourism destination.

In Chapter Three, I trace the historical role of the private sector in health care provision within Costa Rica. The private sector is very small in Costa Rica, and it has relied on the much larger public system for its own survival and expansion, over time. This relationship has become increasingly parasitic, however, and today, the public sector is left caring for the poorest and sickest Costa Ricans, while the private sector focuses on profitable forms of health care. Within popular discourse, the public and private sectors are viewed as disconnected. I argue in this chapter that they are not, and that the maintenance of this division in public consciousness leaves the public system vulnerable to passive privatization.

In Chapter Four, I outline the external pressures on the social medicine system, focusing on the ill effects of neoliberal reform programs and free trade agreements, on health care provision, as well as the way that neoliberalism, as a global hegemonic
system, is changing the way that locals think about health care. These outside pressures have resulted in further contraction of the public system, and impacted the ability of the state to provide health care to its citizens.

In Chapter Five, I focus on local experiences of the medical tourism industry within Costa Rica, outlining the current state of the industry, local hopes and anxieties around its expansion, and the impacts that it has on the public system. I argue here that medical tourism entails a shift of economic and human resources out of the public sector, which cares for the large majority of citizens, and into the private sector, which cares for the wealthy few.

In Chapter Six, I summarize the current contradictions of the political project in Costa Rica, and the competing visions of health nationalism that define the particular moment. In this chapter, I highlight the overarching ideological impacts that medical tourism has in a context like Costa Rica, and its impacts on the way that locals conceptualize health and health care provision.

Research Methods

According to Appadurai (1991), globalization is characterized by the movement of people, technology, money, images, and ideas—which now follow increasingly complex trajectories, moving at different speeds across the globe. Medical tourism, as it adeptly crosses national boundaries, touches on all of these flows. Because the object of study is a global industry that is not situated in one place, this research is multi-sited (Marcus 1995). It utilizes a research framework that both captures local perceptions of global processes and analyzes the systems that connect them. Ethnographic methods are well suited for assessing these interrelations, and, in many ways, the focus of this
ethnography is on these systemic connections.

From October of 2009 to October of 2010, I lived just outside the San José city center, in a neighborhood near the University of Costa Rica (UCR). To address the research questions of this project, this dissertation relied on several foundational methods of anthropology, including participant-observation, interviews, surveys, archival research, and review of popular media.¹

Though classic participant-observation may be impossible in certain settings (Gille and O’Riain 2002), it was used to the extent possible throughout the research period. This a non-traditional ethnography—in that it largely took place within institutional settings and through scheduled appointments with participants at their places of employment or study. At times, I was obliged to rely more heavily on observation than participation, particularly when conducting fieldwork within hospitals and government agencies. Living in Costa Rica for a year, however, did allow me ample opportunity for participation in Costa Rican life, and I took part in several events, including lectures, protests, discussion groups, films, and conferences. Outside of Costa Rica, I attended two (rather dissimilar) medical tourism conferences—the World Medical Tourism Congress, a trade conference for the industry, in 2008, and the International Conference on Ethics in Medical Tourism, in 2010.

While participant-observation is the quintessential method of anthropological fieldwork, it presents a theoretical problem “in that it tends to miss the implications of structures of power and of historical context, because these forces are not immediately visible in every day observations of individuals” (Brotherton 2003). Supplementary

¹ See Appendices A and B for interview and survey guides.
ethnographic methods help to gain a more nuanced understanding of complex global processes to address the shortcomings of static methodologies.

Throughout this project, I conducted individual (48) and group (2) interviews with stakeholders at various levels of the medical tourism industry. In total, I conducted 50 semi-structured interviews with participants—the majority of whom were physicians (29), and male (39). Of physicians interviewed, there was nearly an even split between physicians who worked exclusively in the private sector (12) and those who worked exclusively in the public sector (11), although, of these physicians, only one had never practiced in the public sector. (The reason for the high proportion of private sector physicians in relation to the small size of the private sector is likely because of a site-access issue, which will be discussed in the Challenges section.) The general composition of participants is illustrated in the following two figures:

![Interview Participants by Profession](image)

*Figure 1: Break down of interview participants by primary profession.*
Figure 2: Break down of physicians interviewed by employment sector.

Interviews began in the United States prior to my arrival in Costa Rica. I conducted two phone interviews with representatives of international medical tourism agencies that worked with hospitals in Costa Rica. From there, I refined my interview guides based on information received, and obtained referrals for connections within the industry in Costa Rica whom I could contact upon my arrival to the country. Once in Costa Rica, I used a purposive snowball sampling strategy to find individuals at various levels within the industry, the health care system, and the government. When I felt that I was reaching saturation with responses among stakeholders in the private sector, I started another “snowball” to better include the public sector, and to elicit a wider range of responses and opinions.

Interviews were tape-recorded and either verbal or written consent was obtained from participants, who are kept anonymous. Throughout the fieldwork process, I refined
interview questions to reflect the position of the person I was interviewing, and to learn more about new themes that emerged as the research progressed.

Over the course of the fieldwork period, I conducted over 200 surveys with patients in private hospitals and public–private cooperatives. These surveys included both closed and open-ended questions about access to public and private health care facilities, patterns of use and opinions of each, and opinions of medical tourism within Costa Rica.

This project relied, too, on archival research and regular scans of popular press and media coverage around medical tourism and health care in Costa Rica. Prior to embarking on my fieldwork trip to Costa Rica, I spent the summer of 2009 conducting archival research on the global medical tourism industry, thanks to a fellowship at an International Institute in Austria. Because medical tourism is a relatively new topic within the academic literature, I found reviews of popular press and media particularly helpful, including newspapers, websites, online videos, blogs, and magazines.

Research Assistant

Vitally important to the success of this research project was the fortunate meeting of my research assistant, Karina, who I initially met in a yoga class. She heard about my research project through emails I sent to the UCR prior to my arrival, and was drawn to the project because of previous research that she conducted on the privatization of health care in Costa Rica. Karina was instrumental in helping me navigate the health care system. She also served as a cultural and geographical guide, helping me to understand cultural nuances, locate people and resources that would further the research, and navigate the bus system. She attended all interviews conducted in Spanish to ensure that I
was gaining accurate information, and to help me to see what I was missing or did not yet understand.

In gaining access to certain facilities to conduct this research, we quickly discovered that we made a good team—I had a remarkably easy time gaining access to private facilities (because private sector stakeholders were eager to promote medical tourism to an American researcher)—while Karina, as a Tica, had much better luck steering through the complex bureaucracy of the public sector to find participants. She was invaluable in moving this research forward.

**Challenges to the Research**

My status as an outsider, and an American, sometimes opened doors for me, and sometimes closed them. While my nationality allowed me access to medical tourism stakeholders quite frequently, this turned out to be a disadvantage as well. Early in the fieldwork process, I grew frustrated with what came to be known as “the spiel.” Because my sampling strategy started with actors within the medical tourism industry, I began to hear the same rhetoric about the benefits of medical tourism over and over. When participants started to repeat the exact same words and phrases verbatim, I came to understand that there were heavy marketing and messaging tactics at play here—and that I would have to be more innovative in order to get past “the spiel.” Slowly, I became more adept at using some personal strategies to gain deeper information. In particular, I feigned ignorance in certain situations, appearing merely inquisitive in order to ask about touchy subjects such as *biombos* (bribes) or tax evasion. My non-threatening demeanor seemed to work to my advantage in these settings. Without trying to alter or censor

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2 Tico (male) and Tica (female) are slang terms for Costa Ricans that are popularly used.
participant responses, in situations where I felt that they were giving me “the spiel,” I had
to use my own common sense and other sources of information to get at the underlying
truths. Ethnographic methods are particularly adept at this, and allowed me to conduct the
research in a flexible and creative way.

About half way through my fieldwork, I hit a snag in my research plan when, the
week before Costa Rica was to host an international conference on medical tourism, I
was told by a high-ranking official whom I was interviewing that my research was “too
political.” He demanded to know who had given me permission to study such a topic,
and, as there is no International Review Board within Costa Rica to approve research
projects by foreigners, I did not have a good answer for him. The next month entailed
several meetings with different institutions to try and figure out who exactly could, and
would, endorse my research.

Academics at the UCR, while fond of my research topic, did not have the
authority to sponsor students who were not enrolled at the university. The Ministry of
Health told me that my project was social in nature and that they did not sponsor such
things. They wondered why I was asking for permission, and suggested that I just do the
research and not tell anyone about it.

Finally, the bioethics department of the Caja agreed to review my proposal.
During this time, I learned rather intimately how frustrating the bureaucratic processes of
the Caja could be. After submitting six hard copies of my proposal, I was told that I
would have to wait a month for the proposal to be reviewed. Six weeks later, I heard back
that my proposal was rejected. The reviewers did not understand why I should want to

3 The “Caja” is short for the Caja Costarricense de Seguro Social, or the CCSS. It is the Costa
Rican Social Security System, which provides health services to the population.
study medical tourism, a private industry, within the Caja. If I want to study plastic surgery, they wrote, why don’t I go into the private hospitals? After several months of back-and-forth communications and revisions, I was finally able to make the bioethics committee understand the social nature of my research. But with a limited fieldwork period, I had, in the meantime, drawn on one of the researcher’s most important methodological tools—flexibility. Despite the best-laid plans, fieldwork, especially in a foreign country, sometimes just doesn’t go the way it was hoped. In this case, I had to reassess my project and what was necessary to successfully complete the research—and then adapt.

Because the majority of private sector physicians work within the public system as well, I began to search for public sector physicians who operated private offices part-time, and met with them in their private spaces in order to circumvent my pending permission to conduct research within Caja facilities. While this proved an effective strategy, it did skew my participants toward the private sector side more than is representative of the health care system at large (90% of the nation’s physicians work within the Caja, though not all do so exclusively). Eventually I gained official permission by the Caja to conduct fieldwork in one of their public–private cooperatives, which I did during the last month of my fieldwork period.

Another challenge of the research, though to a much lesser degree, was the use of informed consent. Though consent forms did not seem to inhibit participation in the project, I was told many times that the forms were very “American,” “formal,” and “bureaucratic.” In general, however, Costa Ricans were very amenable to participating in this research, and did so without incentive, other than contributing to a topic that they felt
was important. Having worked in health care settings here in the United States, it was especially surprising to me that physicians were so willing to give their time, as this is a historically difficult group to recruit.

**Data Sources and Analysis**

Several methods were used to analyze data collected for this study. Interviews were transcribed by two students, Alan and Silvia, who worked within the Institute for Social Research at the UCR. Silvia, who had lived for many years in the United States, translated Spanish transcripts into English, and helped to translate surveys, forms, and interview guides to ensure their accuracy.

Survey data was entered and analyzed in Excel. Other data sources included field notes, site descriptions, and background research, which I conducted on certain topics that arose in interviews (for example CAFTA implementation and provisions, contracts between medical residents and the Caja, etc.). These sources were typed into Word documents, and loaded into Atlas.ti, for thematic analysis. A combination of inductive and deductive coding was used to analyze all narrative data, and codes were reviewed and organized for writing.

**Field sites**

This research took place in and around the Costa Rican capital of San José, located in the Central Valley. With a population of over 365,000, San José is home to government institutions, and the majority of the nation’s health care facilities and universities.
I conducted fieldwork at three private hospitals—Hospital Clínica Bíblica, Hospital Hotel La Católica, and CIMA— all of which are accredited hospitals that try to attract medical tourists; I also conducted fieldwork in two of the Caja’s national hospitals in San José—Hospital San Juan de Dios and Hospital Calderon Guardia—as well as in one mixed medicine cooperative, Coopesalud, in Pavas, a district of San José. Lastly, I conducted interviews with students and professors from the UCR, and participated in events through the university. Throughout the dissertation, I offer some more detail about these field sites, as it relates to themes around medical tourism.

**Reflection on Fieldwork**

Though it is somewhat difficult to recall now, my initial decision to study medical tourism in Costa Rica had at least something to do with the idyllic image of the country that is portrayed in the media and popular imagination—and, as a medical anthropologist, its successful social health care system. It is very easy to get caught up in this image. Studying Costa Rica’s health system, I am often solicited to engage in discussion over the merits of social medicine—declaring it either good or bad, and either a success or a failure. While I may have been more amenable to making such a declaration prior to working in Costa Rica, I now have a much more nuanced appreciation of both the positive and negative aspects of the Costa Rican health care system. I have tried in this dissertation to avoid reducing this topic to moral absolutes. I offer a critical perspective of the medical tourism industry and its founding assumptions, but hope to have painted a

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4 Throughout the dissertation, I refer to these three hospitals often as the “big three” private hospitals for simplicity’s sake. They are not the only private hospitals in the nation, but they are the largest, and most well-known.
sufficiently complex picture of the Costa Rican health system that captures the intricacies of the current political moment.

Within Costa Rica, too, many whom I met had an agenda that they thought matched mine—whether this was supporting the medical tourism industry, or exposing the faults of either public or private health care. Understandably, as a researcher, I would like to satisfy all of those whom I imposed upon to participate in this study, and not to betray any of them. It is one of the difficulties of ethnographic research that I cannot make this promise. I can only offer here an account of medical tourism filtered through my own experiences, research and interpretations.
CHAPTER 2: AN OVERVIEW OF THE GLOBAL MEDICAL TOURISM INDUSTRY

Set to soft Spanish folk music, slow motion scenes of Costa Rica appear one by one—a church…a time-worn statue of two angels…an elderly Costa Rican man…school children in uniform playing jump rope outside. Words slowly appear on the screen— “Different Cultures”…a butterfly… “providing new hope”…a sunset.

The scene shifts to Bob, bearded, dressed in a red plaid flannel shirt standing next to his wife Linda. Bob is a middle-aged American, family man, and construction worker, whose deteriorating knees have left him worried that he will not be able to support his family. “Every morning, Bob opens his eyes and wonders how much he is going to hurt that day,” reads the female narrator, “even playing with his dog hurts too much.” He is insured, but his insurance will only cover a tenth of the cost of knee replacement surgery, and he cannot afford the remainder of the cost without going into debt. He is aggravated and depressed; his lifestyle and personality are affected, the narrator tells us.

That is, until Bob went on the internet and found out about medical tourism. He has decided to undergo a double knee replacement in Costa Rica, where he can save $80,000, and receive exceptional services. His trip to Costa Rica will be his first time out of the country, but he did some research and found out that Costa Rica has a health system that performs better than the U.S. health care system.

Bob arrives in Costa Rica to find that he is treated better than he ever has been within the U.S. system. The hospital is expecting him, and staff is ready for pre-surgical tests upon his arrival. “A doctor is waiting on me” he exclaims, “That’s a first!”

His surgeon, Dr. Oeding, is a family man like Bob, and we see scenes of him eating with his children, taking them to school, playing racquetball with his friends. “This time rejuvenates Dr. Oeding, and makes him a better doctor,” reads the narrator. Bob’s wife Linda thinks his nurses “are beautiful, with such lovely smiles… like angels.” Clinica Biblica, the hospital where Bob will receive his surgery, and the technology that is used, is state-of-the-art, and accredited by U.S. standards. The medicines are FDA approved.

Bob and Linda stay at an InterContinental Hotel. After taking a rainforest canopy tour, Bob undergoes his surgery, and it is a great success. His physical therapist, Nazarene, is “focused and competent, giving Bob the emotional and physical support he needs” to recover from his surgery. His surgeon checks on him personally and often during the recovery phase.

On his last day in Costa Rica, Nazarene takes Bob for a walk outside the hospital to be sure that he can handle “real-life” obstacles with his new

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5 Throughout the dissertation, all monetary values will be given in U.S. dollars, unless specified otherwise.
knees before he boards a plane to go home. They cross pot-holed streets and dirty, crowded sidewalks, through a construction site. “This is real-life stuff,” Nazarene says.

Bob returns home to Florida a new man, with a new outlook on life. “The future looks very good,” he says, as uplifting music plays in the background, “each week gets better and better, and better.”

- From *Angels Overseas, a Medical Tourism Documentary (MTA 2009)*

This is the story presented by the medical tourism industry of what medical tourism looks like in Costa Rica—desperate middle-class Americans who travel overseas to be healed by caring “angels,” who not only offer medical care that is comparable to the United States, but also truly care about the health and wellbeing of the patient.

Although the documentary tells us that Bob was in Costa Rica two weeks to undergo and recover from his surgery, he rarely steps outside of the hospital or hotel—except for his quick trip to the rainforest, a popular tourist destination. He is protected from the “real-life” of San José that takes place outside of these purified spaces.

While the images in the passage above represent the “face of medical tourism” presented by the industry, they obscure the reality of medical tourism within destination countries. The emergence and development of medical tourism as a global industry and the primary concerns—ethical, social, and economic—that arise along with the growth of the medical tourism industry, are the focus of this chapter.

**From Individual to Industry: The Global Growth of Medical Tourism**

**Defining Medical Tourism**

The term *medical tourism* is a controversial concept. Recent anthropological literature has critiqued the term for failing to account for the diverse types of medical travel that people undertake, for suggesting leisure or frivolity, and for disregarding the suffering and lived experiences of patients (Inhorn and Patrizio 2009; Kangas 2010; Song
Other terms, thought to more accurately reflect the practice, have been suggested to replace medical tourism, such as medical migrations, medical exile (Matorras 2005), medical refugees (Milstein and Smith 2006), biomedical or biotech pilgrimages, transnational therapeutic itineraries (Kangas 2010), medical or therapeutic journeys. Some use terms that are more broad, like health tourism, or less value-laden, like international or transnational medical travel, medical care abroad, treatment abroad, or just medical travel.

It may be a useful exercise to debate the relative worth of these terms, but it is not the aim of the research presented here. The focus of this ethnography is the formal medical tourism industry that has developed over the past decade; this industry named itself medical tourism, and in fact has gone to great lengths to protect this name. In the interest of drawing critical attention to the power relations at play within this emerging industry and to avoid linguistic de-politicization of this work (Ormond 2011), I use medical tourism throughout the dissertation.

Additionally, while it is important to note that there are patients who cross borders out of necessity or desperation, it is equally important to note that there are many who do not. It has been estimated by some that 80 percent of the medical tourism industry is centered around cosmetic surgery (Tatko-Peterson 2006). The formal medical tourism industry formed itself around a population seeking elective surgeries, especially plastic surgery, at an affordable cost. The industry markets to this population, particularly within the United States—a group of people who are healthy enough to travel, but not so healthy that they do not need care, and a group of people that have enough money to travel to a foreign country, but not so much money that they can pay the high price for care within
the United States without being strained financially. Although it was clear from those with whom I spoke that the “tourism” part of medical tourism was outweighed by the “medical” part, ads within the industry nonetheless play up this sense of adventure, travel and leisure in their promotion of destination countries. Even those patients recovering from elective surgeries rarely do a lot of traveling because they are either too weak, or too visibly bruised and scarred to seek these pursuits, but most medical tourists do bring companions with them, who tend to partake in tourist activities.

Figure 3: Medical tourism ads featuring beaches and other tourist attractions.
(Source, clockwise from top left: Thai Travel News 2011; Escape from America 2011; Medical Tourism Panama 2010; Your Medical Travel 2008; Johnny Foreigner 2010; Surgeon & Safari 2009)

Medical tourism today is an industry with an incredible aggregate potential for growth. Within anthropology, it is valuable to examine the special cases of medical travel, but it is equally necessary to examine the most widespread forms of medical tourism. This ethnography aims to “study up” and to study power (Nader 1974) by critically examining the formal medical tourism industry.
Changing Patterns of Medical Travel

Globalization is not new to health care; people have sought healing in foreign lands for thousands of years. However, this travel now takes a very different pattern than in the past century, as patients now travel from more developed countries to less developed countries to take advantage of lower costs, procedures that may not be available in their home countries, and a relatively high quality of health care. In the past century, it was the more developed nations of the world, such as the United States and the nations of the European Union, that were considered popular destinations for medical and health procedures because these nations had the physicians, facilities, and technology to provide high quality medical services that may have been unavailable in many developing nations. Today, this trend has reversed.

As the demographics of these developed nations change and problems with their health care systems arise—such as long waiting lists for procedures in Canada and the United Kingdom, or the extremely high costs of health care and high rates of uninsured citizens in the United States—patients from these countries are now seeking high quality, low cost health care outside of their national borders. In addition to these demographic and systemic changes, ease of travel, expansion of the internet and global communication, increasing portability of health insurance, and the retreat of neoliberal states from the provision of public services have played a role in the expansion of medical tourism (Kangas 2010; Whittaker 2010b).

In nations that provide public health services to their citizens, like the United Kingdom or Canada, the prime motivation for citizens to engage in medical tourism is to avoid long wait lists for procedures in their own countries. Some medical tourists have also traveled to protect their privacy, particularly when receiving cosmetic surgeries, or to
obtain services for which access was restricted or illegal in their home country (specific examples of these forms of medical tourism will be discussed in further detail in the next section). The primary reason for Americans to seek health care abroad, however, is the lower cost, which in some cases can be as low as 10 percent of the price in the United States. An inefficient market-based health care system in the United States has led to inflated costs of health insurance that now leave 47 million Americans uninsured. Americans who are uninsured, underinsured, and who lack coverage for dental care or elective procedures are the primary populations seeking care outside of the borders of the United States. Contrary to the beliefs of many medical tourism proponents, medical tourism is not a savior for poor, sick, uninsured Americans; the poor do not have the means to travel out of the country for care, and the very ill cannot travel. Furthermore, it is not the elite who travel either, because they can afford the high cost of care within the United States. Rather, it is those who are somewhere in between: middle-class Americans who are not willing or able to pay the high cost of health care within the United States, but do have enough expendable income to travel outside of the United States for care and pay out of pocket. However, as insurance companies begin to consider medical tourism options to save costs, this profile is changing to include more insured Americans.

Medical tourism facilities in developing countries are able to provide services at these reduced costs precisely because of their inferior economic status. Lower fixed costs, wages, and administrative expenses; cheaper pharmaceuticals; and the absence of the litigious medico-legal climate that exists in the United States all contribute to this cost differential (Unti 2009). As an example, the professional liability insurance premium for
a surgeon in India is only 4 percent of the premium for a comparable practicing surgeon in New York (Lancaster 2004).

**The Procedures Medical Tourists Travel For**

Although medical tourism as an industry began with procedures of limited medical complexity like elective procedures or dental care, which are not covered on most insurance plans, it has now expanded into more complex procedures. Today, medical tourists travel for a wide array of procedures, from heart valve replacements to joint replacements to brain and spinal surgeries. The popular press within the United States most often chooses to focus on these more critical procedures undertaken in foreign countries, highlighting the reduced cost. This not only serves as a marketing tool for medical tourism, but also as a reflection on the high costs within the U.S. health system as compared to other countries. This was exemplified with the highly publicized case of Howard Staab, who traveled to India for a heart valve replacement and sparked lively debate about the benefits and dangers of medical tourism and its potential impacts on the U.S. health care system.6

Patients most commonly travel for procedures that are available in their home country but that they have prohibited or limited access to (e.g., because of cost or wait time), but there are those who travel to access procedures that are unavailable in their home country as well. This might be because of limited infrastructure, technology, or

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6 Howard Staab, in many ways, is “patient zero” within the medical tourism industry. In 2004, Staab, 53, uninsured and self-employed, found out that he needed a mitral valve replacement, which cost upwards of $200,000 in the United States. He traveled to India and had the procedure done for $10,000. His partner and travel companion, Maggi Ann Grace, wrote a book about his “lifesaving surgery in India” entitled *State of the Heart*. The two received a flood of press coverage that spurred subsequent discussions about medical tourism.
Table 1: Cost Comparison of Common Medical Tourism Procedures by Country
(Medical Tourism Association 2010)

<table>
<thead>
<tr>
<th>Surgery</th>
<th>USA</th>
<th>Colombia</th>
<th>Costa Rica</th>
<th>India</th>
<th>Jordan</th>
<th>Korea</th>
<th>Mexico</th>
<th>Israel</th>
<th>Thailand</th>
<th>Vietnam</th>
<th>Africa</th>
<th>Malaysia</th>
<th>Nicaragua</th>
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</thead>
<tbody>
<tr>
<td>Heart Bypass</td>
<td>$144,000</td>
<td>$14,802</td>
<td>$25,000</td>
<td>$5,200</td>
<td>$14,400</td>
<td>$28,900</td>
<td>$27,000</td>
<td>$27,500</td>
<td>$15,121</td>
<td>$10,000</td>
<td>$11,430</td>
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<td>$18,000</td>
<td>$3,800</td>
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<td>$15,300</td>
<td>$13,500</td>
<td>$8,060</td>
<td>$5,788</td>
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<td>Heart Valve Replacement</td>
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<td>$18,000</td>
<td>$30,000</td>
<td>$5,300</td>
<td>$4,300</td>
<td>$14,900</td>
<td>$8,000</td>
<td>$29,712</td>
<td>$29,212</td>
<td>$10,130</td>
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<td>Hip Replacement</td>
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<td>$6,500</td>
<td>$12,500</td>
<td>$7,000</td>
<td>$8,000</td>
<td>$14,120</td>
<td>$19,000</td>
<td>$23,250</td>
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<td>$10,840</td>
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<td>Hip Resurfacing</td>
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<td>$6,500</td>
<td>$12,500</td>
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<td>$14,120</td>
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<td>$6,500</td>
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<td>$16,800</td>
<td>$12,000</td>
<td>$24,850</td>
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<td>Spinal Fusion</td>
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<td>$4,200</td>
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<td>Gastric Sleeve</td>
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<td>$6,000</td>
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<td>$4,400</td>
<td>$15,300</td>
<td>$4,900</td>
<td>$16,000</td>
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<td>$3,270</td>
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<td>$1,800</td>
<td>$500</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$1,995</td>
<td>$1,818</td>
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<td>Cornea (both eyes)</td>
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<td>$1,800</td>
<td>$500</td>
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<td>$6,000</td>
<td>$1,995</td>
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<td>$500</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$1,995</td>
<td>$1,818</td>
<td>$1,640</td>
<td>$4,200</td>
<td>$4,777</td>
<td>Not Provided</td>
<td></td>
</tr>
<tr>
<td>IVF Treatments</td>
<td>$4,500</td>
<td>Not Provided</td>
<td>$2,800</td>
<td>$2,700</td>
<td>$2,180</td>
<td>$3,980</td>
<td>$2,800</td>
<td>$9,091</td>
<td>Not Provided</td>
<td>$5,620</td>
<td>$8,810</td>
<td>Not Provided</td>
<td></td>
</tr>
</tbody>
</table>

Transplants when Patients Bring Own Donor:

<table>
<thead>
<tr>
<th>Transplant</th>
<th>India</th>
<th>Jordan</th>
<th>Korea</th>
<th>Mexico</th>
<th>Thailand</th>
<th>Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Marrow Transplant</td>
<td>Not Provided</td>
<td>Not Provided</td>
<td>Not Provided</td>
<td>$135,000</td>
<td>$45,555</td>
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</tr>
<tr>
<td>Kidney Transplant</td>
<td>$8,000</td>
<td>$35,000</td>
<td>$45,000</td>
<td>$45,000</td>
<td>$31,112</td>
<td>$15,450</td>
</tr>
<tr>
<td>Liver Transplant</td>
<td>$13,000</td>
<td>$100,000</td>
<td>$170,000</td>
<td>$135,000</td>
<td>$36,364</td>
<td>Not Provided</td>
</tr>
<tr>
<td>Heart Transplant</td>
<td>Not Provided</td>
<td>Not Provided</td>
<td>Not Provided</td>
<td>$15,515</td>
<td>Not Provided</td>
<td>Not Provided</td>
</tr>
</tbody>
</table>
expertise, or because a procedure is controversial, experimental, or illegal. Prominent examples of these include stem cell, organ transplant, reproductive, abortion, or gender reassignment procedures.

In the case of stem cell tourism, patients travel abroad for stem cell treatments that are not approved within their home countries. This form of medical tourism is likely not as related to cost as other forms, but rather it represents hope for patients seeking a cure for terminal illness (e.g., Parke, et al. 2010; Song 2010). Liberation therapy, also known as venoplasty or vein opening, for the treatment of multiple sclerosis is another example of an experimental procedure for which patients travel. Another example, though significantly less controversial, is hip resurfacing, which is now an accepted alternative to full hip replacement, but was not approved by the Food and Drug Administration (FDA) in the United States until 2006. Indian doctors had been performing hip resurfacing for over a decade by the time FDA approval came through (Neely 2009). Because ethical debates and legislative processes can take a significant period of time and regulatory structures are more stringent in developed countries, medical tourists might choose to seek these procedures elsewhere.

In addition to experimental procedures, there are medical tourists who travel for illegal or highly stigmatized procedures, such as abortion (e.g., Sethna and Doull 2010) or gender reassignment surgeries (e.g., Aizura 2010; Wilson 2010). While not always illegal in their home country, these procedures are often so stigmatized that patients might choose to leave their home country to ensure privacy or anonymity.

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7 See Kangas 2010 for an account of Yemeni travelers seeking treatments not available in Yemen for chronic illness, following a more traditional pattern of medical travel from less developed to more developed countries.
An illegal and highly controversial form of medical tourism that has been gaining attention among researchers and the popular press is transplant tourism. Shortages of donor organs for transplants have created commercial opportunities abroad in the global organ trade. Patients in search of organs can now purchase them on the black market (it is illegal to pay for organs in the United States). This is a way for desperate patients to circumvent the regulatory framework of their countries, but it raises serious bioethical concerns. In developing countries, the poor sometimes sell a kidney for as little as $1,000–3,000; the same organ is then sold to a wealthy patient in a developed country for upwards of $40,000. Especially among the poor, this practice can have very detrimental effects on the health of the organ seller (e.g., Cohen 2003; Cohen 2005; Scheper-Hughes 2002). The medical tourism industry has struggled with this issue, and although most medical tourism associations now say that patients must bring their own donor, there is virtually no regulation of this practice.

Reproductive tourism is another form of medical tourism that has become extremely popular in recent years, sometimes called “procreation vacations” in the press. Due to the high cost of fertility treatments, limited insurance coverage, and legal and policy implications in some countries, women and couples travel abroad for in vitro fertilization (IVF) treatments (e.g., Blyth and Farrand 2005; Inhorn and Patrizio 2009; Speier 2011; Whittaker 2010a). While this practice in itself might not be viewed as ethically questionable, in some cases, the couple may choose the genetic characteristics of the fertilized egg that are most desirable, or have another woman act as a surrogate mother. This surrogacy practice occurs frequently in India (e.g., Kumar 2008; Venkatachalan, et al. 2010), wherein an Indian woman is implanted with a fertilized egg
and carries the pregnancy to term for a couple. The genetic parents can even “shop around,” looking through photos of potential surrogates, even in cases where the surrogate mothers’ genetic material is not used in the process. Potential surrogates must first “prove their fertility” by having one child of their own, and then may act as a paid surrogate up to five times. The rate of cesarean sections among these surrogates is nearly 100 percent. While cesarean sections protect the health of the baby, they are much more dangerous to the health of the surrogate mother, especially when some women undergo the procedure multiple times throughout their productive years (Venkatachalan, et al. 2010).

As Meghani (2010) notes, “different kinds of medical tourism procedures, such as reproductive, transplant and cosmetic, raise different ethical issues.” The forms of medical tourism discussed above raise several significant ethical and moral issues, from eugenic concerns to the post-colonial value of “third world” bodies that are now being used in the service of keeping “first world” bodies healthy. These ethical impacts of medical tourism, as well as the socio-cultural and economic impacts, will be discussed in more detail in Chapter Six. While it is imperative that these controversial gray areas of medical tourism continue to be exposed and critically examined, it is also important to keep in mind, again, that although medical tourism can take place in pursuit of urgent, controversial, or illegal procedures, in its current state, the majority of procedures are elective or non-urgent.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Procedure</th>
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<tbody>
<tr>
<td>Cardiac and vascular surgery</td>
<td>Aortic aneurysm repair</td>
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<td></td>
<td>Atrial septic defect repair</td>
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<td></td>
<td>Cardiac valve replacements: aortic and mitral</td>
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<td></td>
<td>Carotid endarterectomy</td>
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<td>Coronary artery bypass grafting</td>
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<td>Femoropopliteal bypass surgery</td>
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<td></td>
<td>Varicose vein treatments</td>
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<tr>
<td>Cosmetic and plastic surgery</td>
<td>Abdominoplasty</td>
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<td></td>
<td>Blepharoplasty</td>
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<td></td>
<td>Breast augmentation/reduction</td>
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<td></td>
<td>Cosmetic skin refinishing and body contouring</td>
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<td></td>
<td>Face lifts and implant surgery</td>
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<tr>
<td></td>
<td>Liposuction</td>
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<td></td>
<td>Rhinoplasty</td>
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<tr>
<td>Dentistry and oral surgery</td>
<td>Bridges and implants</td>
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<td></td>
<td>Endodontic procedures; root canal surgery</td>
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<td></td>
<td>General dentistry procedures</td>
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<td></td>
<td>Orthodontic procedures</td>
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<td></td>
<td>Tooth veneers</td>
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<td>Ear, nose, and throat surgery</td>
<td>Bronchoscopy</td>
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<td></td>
<td>Cochlear implants</td>
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<td></td>
<td>Nasal septoplasty and reconstruction</td>
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<td></td>
<td>Sinus surgery</td>
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<td></td>
<td>Tonsillectomy and adenoidectomy</td>
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<td></td>
<td>Tympanoplasty and tube insertion</td>
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<tr>
<td>General, colorectal, and oncologic surgery</td>
<td>Bariatric surgery; banding and bypass</td>
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<td></td>
<td>Bowel surgery: colectomy and other procedures</td>
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<tr>
<td></td>
<td>Breast surgery: biopsy, lumpectomy, mastectomy</td>
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<td></td>
<td>Cholecystectomy</td>
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<td></td>
<td>Gastrointestinal endoscopy: upper and lower</td>
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<td></td>
<td>Hemorrhoidectomy</td>
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<td>Herniorrhaphy</td>
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<td></td>
<td>Laparoscopic surgery</td>
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<tr>
<td>Neurosurgery</td>
<td>Treatment of brain tumors</td>
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<td></td>
<td>Treatment of spine disorders</td>
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<tr>
<td></td>
<td>Skull base surgery</td>
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<tr>
<td>Obstetrics and gynecology</td>
<td>Gynecologic laparoscopy</td>
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<td></td>
<td>Hysterectomy: abdominal and vaginal</td>
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<tr>
<td></td>
<td>In vitro fertilization and intrauterine insemination</td>
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<td></td>
<td>Tubal ligation and reversal</td>
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<tr>
<td>Ophthalmologic surgery</td>
<td>Cataract surgery</td>
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<td></td>
<td>Cornea alteration procedures</td>
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<td>Glaucoma treatments</td>
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Table 2 (continued)

<table>
<thead>
<tr>
<th>Orthopedic surgery</th>
<th>Ankle fusion</th>
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<tr>
<td></td>
<td>Arthroscopic and arthroplasty procedures</td>
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<tr>
<td></td>
<td>Carpal tunnel release</td>
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<tr>
<td></td>
<td>Back procedures: diskectomy, laminectomy, spinal fusion</td>
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<tr>
<td></td>
<td>Hip replacement and resurfacing</td>
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<tr>
<td></td>
<td>Knee replacement</td>
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<td></td>
<td>Shoulder surgery</td>
</tr>
<tr>
<td>Transplant surgery</td>
<td>Organ transplantation: heart, kidney, liver, lung</td>
</tr>
<tr>
<td>Urologic surgery</td>
<td>Cystoscopy</td>
</tr>
<tr>
<td></td>
<td>Genitourinary prosthetic implant surgery</td>
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<tr>
<td></td>
<td>Prostatectomy</td>
</tr>
<tr>
<td></td>
<td>Testicular cancer surgery</td>
</tr>
</tbody>
</table>

Medical Tourism Destination Countries

About 20 nations are consistently identified as “legitimate” medical tourist destinations by the popular press and medical tourism companies. Some estimate that as many as 50 countries may be currently promoting medical tourism.

Figure 4: Map of popular medical tourism destinations.
From an industry perspective, there is a certain “blueprint” for destination countries that must be met before medical tourism is promoted there. These include an existing tourism infrastructure, high quality medical care and technology, accredited facilities, a pool of skilled, English-speaking workers and physicians, and capacity within the private sector to promote and develop this industry. These criteria automatically leave out the poorest of nations. Most medical tourism destinations are lower-middle income countries that already have an active tourism industry.

Additionally while quality medical care is essential, these places must also match the tourist imagination for such a trip. They must be considered beautiful, exotic and adventurous—but not so exotic or adventurous that they lack modern amenities. Medical tourists are also shielded from the undesirable “third world” characteristics of the destination, such as poverty, violence, or unsanitary conditions.

In addition to high quality medical services, medical tourists also expect to receive VIP treatment when they obtain health care abroad—personal medical attention, luxury accommodations, door-to-door transportation services, personal care during the recovery period and high quality meals (Turner 2007). Many facilities provide international patients with a hospital suite comparable to a five star hotel, complete with flat-screen TVs, wireless internet access, guest suites and side trips to local tourist sites. Bumrungrad International Hospital in Bangkok, Thailand is the largest private hospital in Southeast Asia and serves over 400,000 foreigners each year (Bumrungrad International Hospital 2012). It is the first, and most well-known medical tourism facility, and is an example of a facility that offers these amenities; it also contains a Starbucks, Au Bon Pain, and McDonald’s in its lobby.
It is not always the modern amenities and concierge services that most appeal to medical tourists. Medical tourists often imagine themselves refugees, escaping an inequitable, unjust, uncaring health care system that does not care about their needs. They are drawn to the notion that warm and caring nurses and physicians in destination countries will spend time with them to assuage their fears, and give them the personalized care that they desire. In Costa Rica, foreign patients who were recovering from plastic surgery felt that health care personnel had a different mindset around health care provision and a concern for the total wellbeing of the patient (Ackerman 2010). This is ironic, because, at the same time, medical tourism is contingent on intensified commercialization and Westernization of medical services in Costa Rica, as well as the expansion of a neoliberal model of health care. At the same time that Costa Rica is seen as peaceful, green, natural and “different” from the United States, it must be perceived as having advanced Western biomedical technology, physicians and standards of care.

It is imperative, then, that destination countries walk these lines. They must be exotic enough, but not so exotic that patients feel uncomfortable traveling there; they must be poor enough for there to be a cost differential in care, but not so poor that they...
are unable to provide quality health care and infrastructure; and they must be seen as fundamentally different from Western notions of biomedicine, while at the same time offering Western biomedical care.

The Current State of the Medical Tourism Industry
Whereas the practice of medical tourism began at an individual level, a powerful industry has formed around this practice within the past decade, and the numbers of medical tourists have increased dramatically. A report by the Deloitte Center for Health Solutions (2008) estimated that 750,000 Americans traveled abroad for medical care in 2007 and projected an increase to more than 1.6 million by 2012, with sustainable annual growth of 35 percent. They further estimated that the worldwide market for medical travel was worth $60 billion, and expected that it would grow to $100 billion by 2020.

Data Challenges and Questionable statistics
These figures are likely the most quoted statistics on global medical tourism, but even these are questionable, and it is not clear how these figures were determined. Inconsistent definitions and methods for collecting and reporting medical tourism data make it extremely difficult to provide an accurate estimate of the number of medical tourists traveling for health care. A researcher who publishes on medical tourism criticized the data collection of major research firms, stating, “Accurate figures on medical tourism are not easy to come by… by definition, almost every official figure is flawed. They are often badly collected, imperfectly collated and spun to infinity” (Youngman 2009).

One of the primary challenges of collecting data is determining how medical tourism is defined. While medical tourism as a global industry has been widely defined as
patients who travel for the specific purpose of receiving medical treatment, this definition does not always translate into attempts to measure the flow of patients, which sometimes include tourists who have an accident while traveling, or expatriates who live in the country and receive regular health care there, as medical tourists. Desires for privacy of traveling patients also results in underreporting of procedures by patients. Additionally, medical tourism statistics seem to change depending on the particular agenda of the reporting agency or facility. For example, when trying to promote the medical tourism industry to patients or investors, numbers of medical tourists tend to be greatly exaggerated by reporting agencies to give the impression that medical tourism is more mainstream and less risky. Some hospitals also inflate their figures by counting the number of patient visits instead of the number of visiting patients. Youngman says that agencies, experts, politicians, and hospitals often “make ludicrous estimates of actual or potential numbers” and gives an example of an Asian minister who said his country had 100,000 medical tourists, while the next week another minister claimed it was 200,000 (2009). On the other hand, when reporting patient numbers to the government for tax purposes, especially within smaller clinics, numbers tend to be under-reported.

After sorting through the data and picking out what he deemed the more reliable sources, Youngman estimated that the number of medical tourists, excluding emergency cases, expatriates, those who travel for wellness or spas, and internal travel, a conservative estimate would be in the range of 5 million medical tourists globally. Despite a scarcity of accurate data, there is no question that medical tourism has increased significantly as a practice, and continues to do so. What is noteworthy is its shift from a very small niche market to a boom in a very short period of time, as the
practice shifts from an individual to an aggregate form.

**Global Actors in the Medical Tourism Industry**

The remarkable potential of medical tourism and its rapid expansion has resulted in a dramatic increase in the number of actors with stakes in this new industry. In addition to the rise in number of associations or facilitator companies that act as intermediaries, the number of insurance companies exploring medical tourism as an option and the number of accredited health care facilities that cater to foreigners have been on the rise. These actors, who serve to oversee and regulate the industry, promote quality services and protect the reputation of the industry, as well as to profit from it, are discussed in the section that follows.

**Medical Tourism Facilitator Companies**

Medical tourism is often part of a package in which all arrangements, medical and otherwise— from obtaining a passport or visa, to flight, ground transportation, hotel stay, meals, and tourism or vacation plans— are taken care of by a single medical tourism facilitator company. Facilitators, formerly called brokerages, take the legwork out of arranging care abroad by working with reputable private hospitals, physicians, travel, and accommodation providers. The number of medical tourism facilitators has expanded exponentially in the past five years. Currently, there are more than 100 U.S.-based facilitators; four facilitator companies have opened in Colorado since 2007. These companies are private, for-profit, and typically owned and operated by American CEOs. They charge fees to traveling patients (or companies who send patients) for arranging these services, as well as a fee to foreign hospitals for providing them with patients, usually a percentage of the total cost of the procedure performed. Although the United...
States has a very high number of facilitator companies, these companies do exist in several other countries (both sending and receiving) as well.

*International Accreditations & Branding*

Turner (2007) discusses the ways that the medical tourism industry “signals quality,” meaning that in order to be successful, the industry must present itself as safe, well-regulated, and possessing the same standards for health care as in the United States. One of the primary ways that medical tourism facilitators and international hospitals signal quality is through international accreditation. U.S.-based Joint Commission International (JCI) is one of several geographically specific accrediting organizations, and the most recognized accrediting body for U.S. patients traveling abroad for care. It was established in 1997 and accredited its first hospital (in Brazil) in 1999. Since then, JCI has accredited over 300 public and private health care organizations in 39 countries (Joint Commission International 2011). Smaller facilities are accredited by separate organizations, such as the Accreditation Association for Ambulatory Health Care (AAAHC), which accredits clinics.

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8 Other accrediting agencies include the International Society for Quality in Health Care Inc. (ISQua), Trent Accreditation Scheme (TAS) out of the UK, Accreditation Canada, Australian Council on Health Care Standards (ACHSI), and Irish Health Services Accreditation Board, among others.
Another way that quality is signaled is through “co-branding” with well-known, medical facilities within the United States and Europe. Respected medical centers in the United States, such as the Cleveland Clinic, Harvard Medicine International, Johns Hopkins Hospital, Duke Medicine, Cornell Medical School, and Columbia University Medical Center, have partnered with hospitals abroad to promote quality services at lower costs (e.g., Deloitte Center for Health Solutions 2008; Milstein and Smith 2007; Sobo, et al. 2011). It must be noted that these U.S. hospital chains retain a portion of the profits made by their international affiliates.

In addition to the highlighting of accreditation and co-branding with Western affiliates, studies of how medical tourism associations and companies market to potential medical tourists have shown that the Western education and training of physicians in destination countries is played up as well (e.g., Johnston, et al. 2010; Sobo, et al. 2011). Ads typically state that most of their physicians are educated in U.K. or U.S. and are board certified (Sobo, et al. 2011). “State of the art” facilities and “cutting edge technology” are also advertised very prominently to signal quality.
International Insurance Companies

Although insurance companies have been slow to adopt medical tourism options, there are several that are piloting programs within their existing health benefit plans. Anthem Blue Cross and Blue Shield of Wisconsin, United Group Program of Florida, Blue Shield and Health Net of California, and Blue Cross Blue Shield of South Carolina are all testing the waters with pilot medical tourism plans, and some third party groups, like United Health Care, have started to reimburse patients for procedures undertaken outside of the United States (Deloitte Center for Health Solutions 2009). In 2006, the United States Senate Special Committee on Aging held a hearing on medical tourism, calling a task force of experts to explore the impact and safety of this practice. In addition, state legislative bills were introduced in both Colorado and West Virginia in 2007 to incentivize state employees to cross borders for health care (Assembly 2007; West Virginia General Assembly 2007). Although neither bill passed, and the Special Committee hearing never amounted to much, these actions were notable in that state and federal legislators were noticing the potential cost savings of medical tourism at an aggregate level.9

The guidelines for medical tourism released by the American Medical Association (AMA) (2008) stated that travelling abroad for care must be voluntary and that domestic alternatives should not be inappropriately limited. While there were no cases of companies requiring that patients travel abroad for care, it is clear that, to date, most insured patients choose not to. Aetna Inc. offered coverage abroad for 27,000 employees

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9 Both bills were viewed as aggressive in the provision of financial incentives, and this may have been a primary reason why they were rejected.
of Hannaford Bros. supermarket chain in the northeast, and two years later, not one employee had chosen this option (Bajgrowicz 2010).

**Medical Tourism Associations**

Medical tourism associations, such as California-based HealthCare Tourism International (HTI), which opened in 2006, and the Florida-based Medical Tourism Association (MTA), which opened in 2007 have been established to promote the industry and protect its reputation. The MTA, in particular, has tried to establish itself as the leading trade association for medical tourism internationally and promotes itself as objective resource for transparency, communication, and education within the industry. The association, made up of international hospitals, insurers, agencies, educational institutions, and other affiliated companies whose purpose is to increase the awareness and utilization of overseas hospitals for medical care, targets U.S. consumers in particular. When launched, the stated goals of the MTA were to promote use of their hospital and clinic affiliates by patients and insurers, to control the growth and standards of the industry (standards based on U.S. criteria), to protect the reputation of medical tourism through quality assurance measure, to act as the representative for dealing with the governments of U.S. and destination countries, and to create a comprehensive website for people to learn about medical tourism (2007).

Although legally a non-profit, the MTA, owned and run by a couple, Jonathan Edelheit and Renée Marie Stephano (both attorneys) has drawn much criticism for using the organization’s non-profit status as a “shield to run profitable activities” (Ratner 2009) and for legally and ethically questionable activities within the sector. Stephano set up a very profitable conference and event business that runs the annual World Medical
Tourism and Global Health Congress (WMTGHC) for the MTA, now in its fifth year, which links medical tourist companies, large-scale employers, insurance companies, and international hospitals into business networks. The registration fee for the congress is $1,200, and priority is given to speakers who sponsor the event (Ratner 2009). Congress sponsors pay anywhere from $500 to $100,000, depending on their level of sponsorship, with higher levels of sponsorship yielding more advertising exposure and other benefits. The MTA also publishes two trade magazines on medical and health tourism, which sell ad space to members and feature destinations that are paying members of the association. To join the MTA, fees are anywhere from $500 (for an individual) up to $5,000 (for medical or pharmaceutical suppliers). Hospitals pay $3,000 for membership, and governments pay $2,000. Additionally, the MTA has a string of trademarked certification programs that members can pay to go through. Critics of the MTA have suggested that the non-profit MTA is merely a shell company for these profitable activities.

Adding to these concerns over the activities and transparency of the MTA, in 2009, the MTA sued another association, Singapore-based International Medical Travel Association (IMTA) over service mark infringement and unfair competition, despite the fact that the two associations have very different agendas and geographic service areas. One commenter wrote, “It is deplorable that the two lawyers who own an association that has only been in the industry since May of 2007 believe they own the words ‘medical tourism association,’ which describes a concept used regularly by the media, the public, and is not unique in any way” (Ratner 2009). Discussion over who “owns” medical

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10 These include International Patient Services Certification for Hospitals and Clinics, International Patient Center Training (which must be received prior to the International Patient Services Certification, Certified International Patient Specialist, and a Medical Tourism Facilitator Certification.
tourism heated up again in 2011 when a writer for International Medical Travel Journal (IMTJ) found that Edelheit had registered 370 web domain names of potential medical tourism websites, including domain names that should belong to competitor conferences and companies, such as the annual European Medical Travel Conference (EMTC) and the Trent Accreditation Scheme (an alternate accrediting body to the Joint Commission International which is more popular in Europe). Additionally, Edelheit registered a domain for a common misspelling of the leading international medical tourism hospital—Bumrungrad Hospital in Thailand (Edelheit registered “Brumrungrad.com”) so that any users who misspelled the hospital’s name would be redirected to the MTA website (Ratner 2009).

Though the accusations discussed above have not been resolved yet, the point must be made that medical tourism is not a benign industry that exists only to provide health care to those in need. Especially as medical tourism continues to shift from an activity of individual patients to an activity covered by health insurance plans, the aggregate potential of the industry is drastically increasing. It has become a big business, with many competing interests and powerful actors involved. There is much profit to be made in this industry.
The Role of Governments in Destination Countries

The level of involvement and role of governments in destination countries varies, though within the industry “blueprint,” there is a plan for how this should work. The MTA promotes what it calls a “health care cluster” in member countries. A health care cluster is generally an independent organization of hospitals, clinics, medical professionals, supporting businesses (i.e., accommodations, transportation, aftercare, and tours) and the government, which all come together to support the medical tourism industry (Cook 2008; Medical Tourism Association 2012). The cluster is funded by all participants and may be supported by government funding. It is meant to represent the interests of all of its members, to promote the members of the cluster, and to build the reputation of the country for medical tourism. The MTA suggests that advertising and

Figure 7: A model of the global medical tourism industry (created by author).
marketing goals be established and that these tie in with the Ministry of Tourism and the Ministry of Health for governmental support. The cluster is to “promote the image of country above all else,” and “regulate who should be able to promote medical tourism within the country” (Edelheit and Stephano 2008). According to the MTA materials on developing a healthcare cluster,

Forming a healthcare cluster is probably the most important single step in establishing a medical tourism destination and to enhance the location’s chances of success as a destination for medical tourists and increasing patient flow. All the medical tourism stakeholders, such as hospitals, doctors, Ministry of Health, Tourism, Economic Development, Tourism Operators, Hotels and more must work together to promote this image of high quality of healthcare to establish a “brand” name for the location throughout the world (Medical Tourism Association 2012).

It further states that over 40 governments are involved in supporting medical tourism, a number that is growing, and that government entities should work together with the private sector on medical tourism initiatives. What is not clear is whether these governments receive any benefits from the industry, or what those benefits might be.

**Global Impacts of Medical Tourism**

Thus far, most discussion of the impacts of medical tourism has been around how this practice will affect the U.S. health care system. Reports within the United States contend that “this growth holds important implications for U.S. health care providers, health plans, consumers, and the government,” (Unti 2009) and may result in a $16 billion loss in revenue for U.S. health care providers (Deloitte Center for Health Solutions 2009). Many health care providers within the United States express animosity towards payers that send patients away and patients who choose to go abroad, therefore eliminating domestic revenues, but expect physicians to provide follow-up care for patients returning home (which has lower compensation). A Costa Rican physician whom
I spoke with told me the story of one of his patients, a woman who came to him for a facelift, for which he charged $3,000. She needed four sutures removed when she returned home to the United States, and her U.S. physician, upset that she had gone to a foreign country, told her that he would charge her $3,000 to remove the sutures. On the other hand, some argue that medical tourism will act as a relief valve for the U.S. health care system, reducing some of the burden, and allowing those who cannot afford care to find it elsewhere. Rather than a solution to the problems of the U.S. health care system, medical tourism is a symptom of its malaise.

Although impacts on the U.S. health care system are prominent in discussions of medical tourism’s growth, very few questions have been asked about what this growth could mean for the destination countries to which patients are traveling. Because the rise of medical tourism is a relatively recent phenomenon, and because accurate data is hard to come by, many of its purported impacts are speculative. Until very recently, critique of medical tourism from the social sciences has been almost nonexistent. Meanwhile, powerful global industry actors have been fervently preaching the benefits of the industry—at home and abroad—since its inception. Their considerable ideological and financial investments in medical tourism have translated into media inundation with upbeat, optimistic accounts of medical tourism and its benefits, and muted criticisms. The following section lays out the proposed benefits of medical tourism on destination country health systems, as well as the potential negative impacts and concerns about this expanding industry at a global level.
The Potential Benefits of Medical Tourism for Destination Countries

The arguments supporting medical tourism are primarily economic. Medical tourism embodies the promises of a neoliberal health care economy and is viewed as a progressive economic strategy by many industry actors, as well as government actors in destination countries.\footnote{Neoliberal discourse and its role in the expansion of medical tourism globally and within Costa Rica will be discussed in detail in Chapter Four.} It boosts revenue within the tourism sector, and does so at a rate estimated to be at least four times higher than conventional tourism (Taborda 2011). It is reported that these revenues do not just stay within the health sector, but impact auxiliary industries as well, stimulating “ripple effects at recovery retreats, hotels, tour operators, transportation services and at the government level” (Cook 2008). Medical tourism is also an important area of growth for foreign investment in destination countries.

The underlying assumption is that increased national revenue translates into improved health care for the citizens of destination countries. Advocates of medical tourism claim that revenue earned through performing medical procedures for foreigners will support the public sector and complement public health efforts, with these effects trickling down to the poor. It is also asserted that medical tourism will create jobs for locals (both within and outside of the medical field), promising to “have important knock-on effects that may benefit \textit{even the poor}” (Economist 2008, emphasis mine).

Proponents also argue that medical tourism will reverse “brain drain” by keeping professionals practicing in their home nations rather than emigrating to practice in foreign countries where pay is higher. The head of Wockhardt hospitals, a large medical tourist hospital group in India, reported that two dozen Indian doctors returned from the United States and the United Kingdom to work in his facilities (Madden 2008).
Many within the industry claim that medical tourism actually increases quality of care within both the public and private sectors in destination countries by improving standards of care, infrastructure, technology and training. Stephano, of the MTA, states that “it raises healthcare standards and increases competition, which raises the bar even in the public sector” (Murray 2009). Others claim that medical tourism is good use of the “excess capacity” of private hospitals, and increases the availability of diverse specialists for the whole population (Bookman and Bookman 2007).

Medical tourism can also serve as source of national pride. Song (2010) discusses the inversion of core and periphery within biomedical research that medical tourism represents, highlighting the story of a Chinese physician who provides stem cell treatments to paralyzed patients who travel from countries conventionally thought to be technologically superior to China to receive this care. The physician justifies his decision to treat foreigners over Chinese patients as a way to assert China’s new dominance and superiority in the field of regenerative medicine (Song 2010). The intersection of medical tourism with national rhetoric in Costa Rica will be discussed in greater detail in subsequent chapters.

**The Potential Harms of Medical Tourism for Destination Countries**

Are we in the wealthy world really so blind and selfish that it does not even occur to us to ask to what extent medical tourism, in the end, boils down to poor countries subsidizing the cost of health care for rich countries? (Reader comment in Milstein 2009)

Critiques of medical tourism, like this one, increasingly suggest that economic and other conjectured benefits disproportionately favor the sending nations and negatively impact local access to health care in destination countries in a number of
ways. In short, the costs of medical tourism to public health provision may outweigh the benefits.

First, as previously mentioned, in order for medical tourism to present a cost differential attractive enough for foreigners to travel, inequities between the sending and receiving nations must remain relatively stable. This means that if destinations countries receive significant boosts in tourism revenue that translate into increased wages for medical tourist physicians, or higher fixed costs or administrative expenses that push the price of medical tourism up, the demand for medical tourism will decline, and the industry will likely shift its focus to other countries that can maintain a better price differential. Medical tourism may also contribute to higher costs of health care within the private sector to create “local free zones” (Blyth and Farrand 2005) in the private sector, as prices increase to levels that are inaccessible to locals.

Similarly, the profits from medical tourism that are supposedly going towards improvements in public health seem to remain almost exclusively within the private sector. Medical tourism contributes to the development of a two-tiered health system where elite, technologically sophisticated hospitals cater to wealthy foreigners, while the impoverished majority must use poorly resourced public hospitals. Although medical tourism did not create these problems, it represents the manifestation of inequitable and inefficient health care systems, and has the potential to worsen existing conditions in developing countries. There is currently no mechanism in place to ensure that medical tourism supports public health care systems in destination countries in a way that helps to alleviate these inequities.
Much of the profit generated by medical tourism remains with foreigners rather than with destination countries. Medical tourism associations, facilitator companies, accreditation schemes, recovery homes, as well as private hospitals and hospital groups in destination countries are often foreign-owned. In addition, many of the physicians that work within medical tourism receive at least some of their medical training in the United States and Europe and hold memberships in medical organization there. Much of the “state-of-the-art” technology that is used within the medical tourism industry is also imported from more developed countries, further diverting revenues. The privileging of Western biomedicine and technology within the industry means more profits stay within the Western world.

Beyond economic ramifications, medical tourism also has implications for the quality of health care within destination countries, as human resources may be siphoned from the public to the private sector. External brain drain—wherein health care personnel leave developing countries to practice in more developed countries where they earn a higher salary—in the presence of medical tourism is being replaced by internal brain drain, as health care personnel leave the public health care sector to work in private hospitals that treat wealthy medical tourists.

Medical tourism was recently cited in Thailand’s physician shortage, as physicians opt to practice at hospitals like Bumrungrad, where remuneration is higher (NaRanong and NaRanong 2011). Many of these destination countries are already plagued with human resource shortages. Between 1990 and 2004, India had only 60 physicians per 100,000 people, while the United States had 256 physicians per 100,000 of its population, and yet Thailand and India are the leading destinations for medical tourism.
Physicians often choose, as well, to specialize in procedures that cater to foreign demand, rather than preventive or primary health care.

Overarching these more tangible effects of medical tourism on economic and human resources are impacts at an ideological level. Medical tourism operates from the fundamental assumptions that health is a commodity subject to the forces of the market, and that a neoliberal health care model is the most effective way to provide health care. There is irony in the fact that medical tourism subsists on the failings of this model of health care in developed nations. The rapidly expanding trade in health care has implications for the health systems of both sending and receiving countries, but more fundamentally on the view of health as a commodity rather than a right and global public good.

**The Research Project**

There are significant gaps in our understandings of this new configuration of health care mobility and its implications. This research critically investigates these potential and actual impacts of medical tourism on the health systems of destination countries. Medical tourism, as a global industry, represents a new form of health care in an increasingly interconnected world. It raises many questions about the shifting role of the state in health care provision, global governance for this emerging industry, and the effects that neoliberal models of health care have on destination countries with very disparate health care systems. Among destination countries, Costa Rica stands out because of its successful socialized health care system and the principles on which it was founded. It provides a unique case study to examine the effects of this emerging health care economy and its ideological contradictions. In the chapters that follow, both global
and local aspects of the medical tourism industry, as well as its implications, are examined within the specific Costa Rican context.
CHAPTER 3: HEALTH WITHOUT WEALTH— THE COSTA RICAN CONTEXT

To understand local impacts on health systems, it is important to first situate the research within the Latin American and Costa Rican contexts. Although global medical tourism is becoming more standardized on the side of the industry with the emergence of international actors and standards, it cannot be assumed to have a homogenous effect across destination countries that are very different politically, culturally, socially, historically, and economically.

This chapter briefly discusses health systems in Latin America, before shifting to an in-depth discussion of the Costa Rican context. It includes an overview of national and health system history and development, the complementary role of medical education, and local opinions of the health system. I argue in this chapter that Costa Rica very much fits the “blueprint” criteria of the global medical tourism industry, but that its national health achievements are based on very different ideologies than the medical tourism industry. On one hand, Costa Rica’s successes have been the result of a strong welfare state and progressive social policies that view health care as a right to which all are entitled, while on the other hand, medical tourism is based on neoliberal principles that view health as a commodity, to be purchased by those who have the ability to pay. This chapter will serve as an introduction to several of the themes that will be expanded upon in later chapters.

Social Medicine in Latin America
While nations in the Latin American region developed along different trajectories, general similarities among their health systems do exist, primarily an orientation towards
social medicine. Though defining social medicine can be complicated—and politically loaded—social medicine most generally refers to a state-supported system of health care delivery. This means that the government could fully control the delivery and financing of health care, though in practice, socialized medicine represents a range of strategies, from complete government ownership of facilities and employment of health care providers, to public financing of private insurance and providers. In Latin America, the principles underlying social medicine—beliefs that social and economic conditions impact health, that the health of the population should be a matter of social concern, and that society should promote health and provide health care services—have played prominently in health system development (Waitzkin, et al. 2001). Because of this, Latin American countries historically have placed high priority on social welfare programs, particularly education and health, and these programs have often focused on the poor. These nations have seen remarkable improvements in health indicators over time, with the average life expectancy for Latin America and the Caribbean increasing from 57 years in 1960 to 70 years in the year 2000. Nonetheless, there remain significant intraregional differences in health indicators and achievements. For example, in the year 2000, Costa Rica and Cuba had the highest life expectancies in the region, at 78 and 77 years, respectively, while Bolivia and Guyana had the lowest at 63 years—a striking 15-year gap (Soares 2009).

Despite very different state orientations in Cuba and Costa Rica, both have been lauded as examples within Latin America of the power of “political will,” over economic wealth, and a message to the world that positive health indicators and developing countries are not mutually exclusive (Morgan 1989). In Costa Rica, the shaping of health care priorities was tied strongly to political rhetoric around its longstanding democratic
values, whereas in Cuba, it was tied to rhetoric around Communist values. The key components of political will, described by Rosenfield (In Morgan 1989), are a “historical commitment to health as a social goal, a social welfare orientation to development, widespread participation in the political process, equity, and inter-sectoral linkages for health,” which, combined, can overcome political, economic, or technical obstacles.

Discussion of political will was spurred by the Alma Ata Declaration of 1978, which promoted political will as an essential element of primary health programs that governments of less developed countries had a responsibility to provide for their underserved populations.

Although a commitment to social medicine worked better in Costa Rica and Cuba than in some other countries in Latin America, Morgan (1989) critiques the idea of political will as diverting attention from global power relationships. Attributing health care successes to political will puts attention on the nations themselves, instead of outside global forces and international agencies that often shape health care policies. This, then, shifts the blame for inequitable health care systems to a lack of national will, instead of on inequitable global conditions—a “blame the victim” mentality. Indeed, the message of state responsibility for health care put forth by Alma Ata became convoluted, with the spread of neoliberal health reforms in the 1980s by international agencies (particularly the International Monetary Fund and the World Bank). The impacts of these reforms in shaping health care policies in Costa Rica will be discussed in Chapter Four.

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12 The Alma Ata Declaration adopted the 1948 World Health Organization definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,” recognized the gross inequity in health status between the developed and developing world, and set the goal of “Health for All” by the year 2000, which would be reached through the development of participatory primary care initiatives by governments.
In any event, historically, the nations of Latin America all adopted social medicine to varying degrees, and though they had different visions for how health care would be provided, they shared an underlying philosophy that health care would be provided to all citizens, as a human right and a social good to which all citizens must have access.

Costa Rica as a Case Study

Costa Rica's successful socialized health care system makes it an interesting case study for examining the interaction between medical tourism, a global private industry, and local health care delivery, which is almost exclusively state-sponsored. Bordered by the Pacific Ocean to the west and Caribbean Sea to the east, Costa Rica is about 19,700 square miles in size (it could fit inside of West Virginia) with a population of just over 4.5 million people. It is a standout in Central America, with very high education and health indicators, and no standing military. It is one of the world’s longest standing democracies and has one of the most successful universal health care systems in the world, covering over 90 percent of its citizens. Tourism is the number one industry in Costa Rica, and it is particularly known for ecotourism because of its progressive national environmental policies and biodiversity. In recent years, Costa Rica has become a popular medical tourist destination as well, attracting many Americans in search of high quality, low cost health care.

Colonial History

Although Costa Rica certainly shares cultural and historical similarities with its neighbors, it is also unique within Central America. Costa Ricans trace their democratic roots to colonialism (Biesanz, et al. 1998). Though Costa Rica, like the rest of Central America, was colonized by Spain, Spanish colonizers found a very different situation
when they arrived in 1502. Whereas other Central American nations had large indigenous populations and a great deal of gold or silver to be exploited, Costa Rica did not. Thus it became a lower priority colony to the Spanish, and was largely ignored by colonizers. This lack of attention and interest seems to have had a profound effect on its course of development.

Without human labor or mineral wealth to be exploited, very few Spanish settled in Costa Rica. Those who did, having no indigenous labor to set up feudal colonies, became subsistence farmers. Because there was no exploitation of local peoples, relations between the Spanish farmers and the very small indigenous population were relatively peaceful; there were no class divisions. This “rural classless democracy” is the foundation of the country. From these small subsistence farmers rose the coffee elite, who would form the first government—a government that was egalitarian and accommodating towards the indigenous population (Biesanz, et al. 1998).

This, anyway, is the highly romanticized, and often told, myth of Costa Rican development. This idyllic picture of the colonial encounter has been all but debunked—though it is true that the violence between settlers and the indigenous in Costa Rica occurred to a much lesser degree than in other Central American nations with high indigenous populations. In neighboring nations, ethnic and class conflict played an enormous role in national development, which was marred by extensive periods of violence. In Costa Rica, the democratic origin of the nation was interrupted only a brief period of violence—the 44-day civil war of 1948, which ended in the 1949 abolition of the military. During the war, the United States supported the social democratic Partido Liberación Nacional (PLN, or National Liberation Party), opening the door to U.S.
intervention in Costa Rica. While the U.S. has a long history of intervention in Costa Rica, it pales in comparison to the rest of Central America, which experienced far more invasive U.S. action through the 1980’s. Most notably, the United States led political and military counter-insurgencies in El Salvador, Guatemala, Nicaragua, Panama and Honduras, which left hundreds of thousands dead (e.g., Manz 2004; Robinson 2003). American imperial intervention in the region began in the 19th century, and continued through the 1980s, with many detrimental consequences. In many ways, this imperialism defined the development of the region. The contemporary expansion of industry into the Central American region is, in many ways, a manifestation of this legacy.

The colonial history of Costa Rica has impacted the way that Costa Ricans imagine themselves. The comparative lack of ethnic conflict in Costa Rica allowed the nation to develop in what they consider a very “European” way. Today, less than one percent of the Costa Rican population is indigenous, compared to 30 percent in Mexico and 40 percent in Guatemala. Costa Ricans think of themselves as both “whiter” and smarter than other Central Americans because of their (supposedly) pure European ancestry and adoption of European education systems. Biesanz et al. (1998) calls this the Costa Rican leyenda blanca (white legend).

The “egalitarian myth” of national development also remains prominent in the national identity of Costa Rica, and it is considered to have been the impetus for the “natural” emergence of democracy and peace in Costa Rica. Costa Rica is often referred to as the “Switzerland of Central America,” because of its global neutrality and lack of military. These unifying myths, as well as its standout accomplishments as compared to the rest of Latin America, contribute to the notion of Costa Rican exceptionalism —that
Costa Ricans are whiter, smarter, more peaceful, democratic, and egalitarian than their neighbors (Robinson 2003). These idyllic images have been appropriated globally, contributing to Costa Rica’s development as a tourism destination generally, and, more specifically, a popular ecotourism and medical tourism destination.

**Health System Successes**

This legacy contributed to the successful development of the Costa Rican welfare state, and particularly its universal public health system. Although its national gross domestic product (GDP) is far eclipsed by the industrialized nations of the world, Costa Rica's health indices are the best in Latin America, with the exception of Cuba, and rival those in many of the world's most developed nations. These outcomes are the result of a well-developed, publicly funded, comprehensive health care system built on principles of solidarity, universality, and equity. This Central American success story has often been lauded as a potential role model for other developing nations seeking to achieve “health without wealth” (Morgan 1987; Morgan 1989).

The country’s per capita income is one fourth that of the United States, and approximately the same as that of Mexico; however, Costa Rica's health and equity indicators are more comparable to the United States' and well above Mexico's (Unger, et al. 2007). In 2009, Costa Rica spent 10.5 percent of its GDP on health care and was ranked 36th in the World Health Organization’s rankings of health systems, while the United States spent 16.2 percent and was ranked 37th (World Health Organization 2000). Costa Ricans are deservedly proud of their health care system, and it is a prominent part of national identity. Those who I spoke with did not hesitate to tell me that the health indicators in Costa Rica are better than those in the United States. One physician beamed,
Did you know that we are ranked better than the United States for our national health system? Yes, we are number 36 in the world, and the United States is number 37. And we are the size of state... no, maybe one county in the States. Costa Rica is Costa Rica thanks to its national health system.... Without any doubt it is the best thing that we have in Costa Rica. We have some problems, like any country has—developed or developing—when you talk about public health...but generally speaking, we are really lucky to be in this country. (16)

There is particular pride in being considered more successful than the U.S. health system, which is viewed as unfair and inequitable because of its orientation to approaching health care as a business rather than a social responsibility. I spoke with a retired physician from the public health system who told me,

The public system in Costa Rica—what it does is it protects the population. And if there is profit in public programs, they are reinvested for more public benefit. However in the private sector, the benefit goes to shareholders—to distributing dividends. There is not much reinvestment, and any reinvestment that there is goes to increasing profits, so the gain is not for the majority, but for the owners of the private service. In the United States, this is very clear. In the United States, 25% of the population does not have medical coverage of any kind because they do not have health insurance. [Shakes his head, pauses for a moment then smiles]... There is this program on the television called “Emergency Room” or something like that. That program is such a fraud! Because there they are [U.S. doctors] running around with the patient, shouting that they are going to do a scan, give him a transfusion, and whatever else. None of that is going to happen if the companion [who came in with the patient] can’t demonstrate that he has health insurance. If he does not have insurance, they take him out through the back door without doing anything at all to him! (8)

The U.S. health care system was often criticized by participants as having a great deal more money than the Costa Rican system and yet still failing to provide care to its citizens. This failure is, after all, the reason why medical tourists come to Costa Rica in

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13 Participants in the study are anonymous, but I assigned participant numbers for reference. Throughout the dissertation, when I directly quote a participant, I reference their participant number in parenthesis after the quote. A list of general individual characteristics can be found in Appendix C.
the first place. The blame for the shortcomings of the U.S. system was placed most often on its neoliberal principles that viewed health as a commodity rather than a right. In Costa Rica, it is implied that they have the “right idea” about health care, since they have been able to achieve such successes spending roughly one-fourth less per capita than in the United States. Ironically, in March of 2010, even conservative talk show host Rush Limbaugh famously said that he would go to Costa Rica for his health care if the proposed reforms to the U.S. health care system passed—an odd choice for someone so fervently against universal health care (Long 2010b). In Costa Rica, everyone—even resident foreigners—is required to pay into the government-run health system, whether they use it or not.

Table 3: Health and Equity Indicators for Costa Rica, the United States, and Mexico. (Unger, et al. 2007)

<table>
<thead>
<tr>
<th></th>
<th>Costa Rica</th>
<th>United States</th>
<th>Mexico</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita (a)</td>
<td>$9,460</td>
<td>34,320</td>
<td>8,430</td>
</tr>
<tr>
<td>Health expenditure per capita, $</td>
<td>562</td>
<td>4,887</td>
<td>544</td>
</tr>
<tr>
<td>Infant mortality (b)</td>
<td>9</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>Life expectancy at birth (c)</td>
<td>78.0</td>
<td>77.0</td>
<td>73.3</td>
</tr>
<tr>
<td>Gini index (d)</td>
<td>46.5</td>
<td>40.8</td>
<td>54.6</td>
</tr>
</tbody>
</table>

Note. GDP = gross domestic product.

All data are for 2001 with the exception of the Gini index, which reflects 2000 figures. Data were derived from the United Nations Development Programme.

(a) Purchasing power parity.
(b) Probability of dying between birth and exactly 1 year of age, expressed per 1000 live births.
(c) Number of years a newborn infant would live if prevailing patterns of age-specific mortality at the time of the infant’s birth were to stay the same throughout his or her life.
(d) Measurement of inequality in the distribution of income or consumption within a country on a scale of 1–100.14

14 These figures are from 2000, but I mention in a later chapter that Costa Rica’s Gini index has risen to 50.31.
History and Development of the Health System

Costa Rica developed its public health system gradually. Before 1941, the Costa Rican system was disjointed, made up of private or charitable medical care without central organization. In 1941, President Rafael Angel Calderón Guardia created Costa Rica’s Social Security Administration (Caja Costarricense de Seguro Social, or the CCSS), popularly referred to as La Caja.\textsuperscript{15} The Caja began as a system for wage earners that gradually expanded to cover to the rest of the population over the next 50 years. At the time, there was extraordinarily strong opposition to the formation of a social insurance system. The majority of the nation’s physicians, as well as the Unión Médica Nacional (National Medical Union)—the first union of its kind within Latin America—adamantly opposed a social security system because of the impact that it would have on private medical practice. In fact, union statutes stated that its primary function would be to oppose the development of a social insurance system.

However, Calderón Guardia and his followers enjoyed a great deal of political power at the time, and when the social security system gained support from both the Catholic Church and the Communist Party, it eventually won out. The leader of the Catholic Church in Costa Rica at this time was Monsignor Sanabria, whose education in Europe had convinced him that the Church had a social function in worker – employer relations. The Communist Party, established in Costa Rica in 1934, held as one of their main tenets that social insurances to protect health must exist. Although the Catholic Church and Communist party were not aligned ideologically, they both believed strongly

\textsuperscript{15} Throughout the dissertation I refer to the CCSS by its popular name, “the Caja,” which literally translates to “the box.” Costa Ricans and the popular press refer to the CCSS as the Caja and all of my participants referred to it in this way.
in the labor movement, and were willing to briefly join forces to ensure that it succeeded (Cruz 1992).

It is important to note that the development of the public social security system was tightly linked to increasing work productivity and economic development, as it originally covered the productive workforce only. In fact, the private health care system that preceded the Caja is often said to have been influenced by the United Fruit Company’s (UFC) presence in Central America and their desire to both “civilize” their native employees and keep them healthy to protect the company’s productivity (Aliano 2007).16 The UFC, a U.S.-based company that established “banana republics” in Central America to sell fruit to the United States and Europe, is often called the archetypal multinational corporation. It was known throughout the region for its imperial practices, worker exploitation, and poor working conditions. The legacy of the UFC’s presence can still be seen today in Costa Rica’s two major exports—while coffee is viewed as the darling of the nation and part of the egalitarian and organic roots of the nation, bananas are often vilified as representative of imperialism and outside influence.

In 1949, after the brief civil war, Costa Rica ratified a constitution that abolished the national army, enabling funding to flow toward social programs such as education and health. With these new social investments, steady health sector improvement continued, and in 1973, the General Health Law placed all health treatment services, including primary care facilities and hospitals, under the control of the Caja. This legislation also set

16 The United Fruit Company (UFC) was also complicit in the Guatemalan civil war when heads of the UFC, who had underreported their land-holdings to the Guatemalan government, feared that the newly elected Guatemalan president, Jacobo Arbenz, was going to redistribute their land to the poor. UFC accused Arbenz of being a communist and, in response, the CIA engineered a coup of the Arbenz government. A 36-year civil war resulted, which left 200,000 dead, mostly indigenous people. It was declared a genocide by the U.N. (Manz 2004, Robinson 2003).
provisions for the continued expansion of the Caja until it eventually became a universal health insurance system. In Costa Rica, the right to health is written into the constitution, and the country has authorities both inside and outside the health sector to oversee and safeguard this right: the Sala Constitucional de la Corte Suprema de Justicia (Constitutional Chamber of the Supreme Court, popularly referred to as the Sala IV), an ombudsmen’s office called Defensoría de los Habitantes (the “People’s Defender”) which exercises oversight on the timeliness and quality of health care, and the Ministerio de Salud (Ministry of Health) which oversees the rights and duties of health system users, both public and private.

Within Costa Rica, and globally, this era from the 1930s to the 1970s is seen as a “golden age” of social programs and welfare states, in which stable development and economic growth allowed for the expansion of social policies and a greater role of the state in promoting these social rights (Waitzkin, et al. 2001). It was during this time that the institutionalization of medical practice in Costa Rica began, when the country’s first medical school became linked to the Caja, and newly-graduated physicians began entering the health system through the social security system. This joining of education and health care further entrenched the nation within a framework of social medicine.

In Costa Rica, “the social security system was widely embraced as a project of nation-building, modernization and social equalization” (Ackerman 2009) and the production of physicians, patients, and healthy citizens all became the business of the state. The nation embraced the path to modernization through biomedicine, and the health of citizens—mediated through access to biomedical services—became linked to the social, political and economic well-being of the nation. Individual health became symbolic to the
health of the nation, or to the “body politic” (Scheper-Hughes and Lock 1987). Under this system, physicians became the most important civil servants in the nation, and held a prominent symbolic role in national identity (Palmer 2003). The development of the social security system in Costa Rica not only came to define what it meant to be Costa Rican, but also institutionalized the state’s role in the everyday lives of its citizens.

Medical Education and the Institutionalization of Medical Practice

As mentioned in Chapter One, a major concern about the effects of medical tourism in destination countries has to do with the management of human resources, and the potential “brain drain” of health care personnel from public to private care within these countries. In Costa Rica this is of particular concern, as health care is not only provided almost exclusively through the public sector, but medical education and training of physicians are subsidized through the public sector as well. Public universities, particularly the University of Costa Rica (UCR), are inextricably linked to the Caja. The institutionalization of medical practice within the public sector makes the following discussion of medical tourism more complicated, as it is nearly impossible to think of the nation’s physicians, including those who treat medical tourists, as separate from the public system that formed them.

According to the Costa Rican constitution, primary education is compulsory. By law, public expenditure on education, including higher education, must be at or above 16 percent of the annual gross domestic product. Although not the case for primary and secondary schools, public universities in Costa Rica are considered of much higher quality than private universities, and private universities in Costa Rica are often dismissed as second rate. A recent study by CONARE (a consortium of the country’s public
universities) showed that 85 percent of final year high school students want to pursue a degree at a public university (Long 2010a). Costa Rica currently has five public universities—the oldest, largest and most prestigious being the UCR. Approximately 39,000 students attend the UCR, which is located in San Pedro, just outside of San José’s city center. Admission is very selective; applicants must take a test for entry and have good high school grades. In 2009, of the 31,042 students that completed the admission test, only 16,593 scored highly enough to be admitted to the university. Even then, this does not ensure that they will be admitted to their chosen department or major. In 2007, 60 percent of admitted students were accepted into their desired major (University of Costa Rica 2012). Once students are accepted into the UCR, their education is highly subsidized, and even those students who do pay tuition (many do not) pay negligible tuition fees of roughly $80–$250 per semester. In contrast, private universities have no such admission requirements and essentially accept any student who can pay the tuition, which might cost up anywhere from $500 to $4,000 per semester, depending on the degree program and the university (Long 2010a).

A Ministry of Health Official whom I spoke with, said, “The UCR has prestige equal to that of the Caja; nobody can take it away from Costa Rica” (12). The UCR is internationally recognized for its high quality of education and is considered the most important research university in Central America. Many of the nation’s past and current leaders attended the UCR. It defines itself as a highly democratic, humanistic institution in contrast to technocratic government that ignores citizens. Community participation is expected of students, and forms of social commentary including protests and social movements are accepted, and even encouraged, by the university and its faculty.
In April of 2010, I co-presented a paper at the UCR with Karina. The conference was called *Nuevas Voces en Ciencias Sociales* (New Voices in the Social Sciences) and it took place in the *Instituto de Investigaciones Sociales* (Institute for Social Research), an institute formed to voice critical perspectives within the fields of the social sciences. The conference was entirely student-organized and lasted two days. I was feeling particularly frustrated with the way that the fieldwork had been going at this time; just the week before I had been told that my work was “too political” and started negotiations with the Caja to endorse my project, and, more generally, I was becoming discouraged with my interviews in the private sector, where I was hearing “the spiel” a little too frequently. In my field notes that week, I wrote:

> The conference took place in a small, very basic classroom in the Instituto. It is stark white, outfitted only with orderly rows of wooden tables and some chairs. There are outdated posters on the wall, tearing at the corners. About 30 or so people are present for the opening of the conference, even though it is only 8 am. Though it is early, it is already hot and humid. The windows are open, and the waking sounds of university life can be heard. As the day goes on, yells from a nearby soccer game float in through the open windows and snippets of passerby conversations are heard. Occasionally, it rains, hard. The microphones go in and out during the presentations but no one seems to mind. They are fully engaged, and the atmosphere feels informal, but important.

> It is a relief for me to be here. After spending so much time among those with high stakes in the medical tourism industry, who tout its praises without forethought or without concern, I feel at home in this university environment. People are interested in what we have to say, and have thoughtful comments. In our discussion after the presentation, we find that many are critical of medical tourism, and a few are even enraged at the practice. They are concerned, as I am, about the consequences of medical tourism for Costa Rica. There is a sense of solidarity here in this room, about what it means to be Costa Rican.

*Excerpt from Field Notes April 27, 2010*

There is a strong spirit of social activism at the UCR; I witnessed many instances of this, including public marches for or against presidential candidates during the February
2010 election, performances and documentaries produced by students and faculty, and protests over social and political issues. I arrived at the campus one day to conduct an interview only to find that the university had been shut down without notice, so that students and university employees could have the opportunity to protest the government’s proposed financial commitment to the Special Fund for Higher Education (FEES), which was to be cut, and demand an increase in education funding.

**Medical Schools**

The number of medical schools has grown significantly in recent years; there are now eight in the country. Like universities in general, there are both public and private medical schools in Costa Rica, but the public ones are known as being much better in every field. The UCR has the most respected medical school in the nation, and likely in Central America.

The UCR was created in 1940, alongside the Caja, during the reformist administration of President Rafael Ángel Calderón Guardia and it grew in tandem with the Caja. Like the Caja, it is considered a foundational institution and plays a prominent role in Costa Rican national identity. A retired physician and professor who was instrumental in the development of both the Caja and the UCR had this to say about the intertwined history of these institutions:

> It was a parallel development. We organized and opened the medical school because there was no medical school in the country and it was absurd to think that we could have a national health system if we did not have a factory to create the workers for the system—the doctors. So, parallel to the political project, I developed the academic project... organizing the commission to open the medical school, developing the first courses and I was one of the first university professors that the medical school had in the country. (8)
The special relationship that the UCR shares with the Caja is often criticized by other universities, particularly private ones, who feel that the preferential treatment given to UCR students puts their own students at a disadvantage in receiving medical training, and in finding work post-graduation. Despite this criticism, however, receiving a residency position has become more political over the years, and private university students are now able to get positions based on money or personal connections more often than in the past. UCR medical students and residents whom I interviewed felt that this was unfair, and that they were much better prepared to become a physician than their peers from private universities whom they sometimes had residencies alongside. The tension between public and private institutions has been increasing as the private sector begins to take a more prominent position in Costa Rican society, a topic that will be explored further in the next chapter.

Medical Residencies

By virtue of graduating with a medical degree from an undergraduate university, which typically takes four to five years, graduates become general physicians. Only those who continue on to become specialists receive residency training in Costa Rica, and only the Caja provides this training. The time of residency varies depending on the specialty; a residency in pediatrics is four years, while a residency in neurology takes ten. During the residency period, residents work as a general doctor and are paid as one (about 2-3 million colones, or $4,000–$6,000 per year), but complete “shifts” within their specialty, which supplements this base income substantially. Upon completion of the residency, specialists receive placements within Caja facilities, their salary increases, and they are expected to work fewer shifts.
Because there are a limited number of residency slots open in the Caja, getting a residency is not only somewhat political, but it is very competitive as well. About 450 medical students each year graduate from all 8 medical schools in the country, with about 80 of those coming from the UCR. Of 1,300 graduates who would like to pursue specialties, about 250 pass the first test to become a specialist. Those who pass then have to take a second test for the particular specialty they wish to apply for. Most physicians whom I spoke with had taken the specialist test more than once. In the neurosurgery specialty, which is considered one of the most difficult, there were four openings in 2009. Only three physicians took the test, and none passed. In this case, the four positions were not filled and remained open for the next year. Furthermore, even if the applicants do pass the extremely difficult examinations, they are not guaranteed a residency. The number of spots available depends on the number of residents needed within that particular specialty, a figure that is calculated by CENDEISSS (Centro de Desarrollo Estratégico e Información en Salud y Seguridad Social, or the Center for Strategic Development and Information in Health and Social Security). So, there might be ten spots open in a particular specialty and twenty applicants who have passed the two tests, in which case only the top ten will get a residency position. Within general surgery, 100–150 people sometimes compete for 4–6 spots. It is not unheard of for some physicians to apply up to 20 times without getting a residency.

Those who cannot get a residency position must choose to either keep applying (possibly in a different specialty), work as a general physician, or change careers altogether. Some who cannot obtain a residency move to the private sector and open medical offices there. The problem with this is that, up until recent years, patient volume
in the private sector has been so low that it is difficult for an unspecialized physician to make a living solely with a private practice. However, political changes and the promotion of medical tourism have opened more opportunities for physicians in the private sector. Some of these unspecialized physicians advertise themselves to medical tourists as being able to perform procedures at a lower cost, even though they might not be licensed in the area of specialty. Specialists who work in more “legitimate” medical tourism facilities caution against using these physicians, who can tarnish the reputation of the industry, and are a danger to patients—they are “peligroso bruto” (a dangerous brute), according to one participant (28).

In sum, the medical residency within the Caja is extremely important because it is the only place where the nation’s specialists are trained. The special relationship between the UCR and the Caja continues during the residency period, as almost all medical residents are concurrently UCR students and Caja employees, where they not only earn a salary, but also begin to accrue seniority, and receive all the bonuses, incentives, and benefits of other Caja employees. Once employed by the Caja, health care personnel move up the ranks based on their years of experience working in the public system. They are able to accrue higher salaries and more employment benefits as tenure continues. A career within the Caja is considered to be very stable; it is nearly impossible to get fired. Some criticize this tenure system, however, as being poor incentive to increase work performance (a topic that comes up again in later discussion of neoliberal actors).

**Quality of Care in the Caja**

The Caja subsidizes medical education and trains the nation’s physicians with the expectation that they will remain in the public sector serving Costa Ricans. After
residency training is complete, physicians typically do remain in the Caja because it is where they gain experience. The sheer number of patients and pathologies within the public sector allows physicians to gain skills very quickly. The medical director of a private hospital, who had worked in the Caja earlier in his career, said:

If you did not work in the Caja you do not have experience. Because the patient volume that you see in the private sector is very little compared to the volume which you see in the public sector, and the majority of rare diseases or complicated diseases you do not see it here [in the private sector.] The private hospitals are “light” hospitals, as we would say. They are hospitals that do liposuction, remove a vein, operate on a knee… but when a piece of the colon has to be removed, a very big tumor, etc., everything like that is in the Caja. So if you have not worked in the Caja, what experience are you going to have? (12)

The Caja provides excellent training for physicians, and almost all of the nation’s physicians work, or have worked, in the public sector. Despite my sampling method of locating Caja physicians within their private practices, discussed in the Introduction, only one physician that I interviewed had never practiced in the Caja at all (in this particular case, he decided to go back to medical school later in his life and was happy with a small practice as a general physician in the private sector.)

Partly due to the rigorous training and vast experience that physicians gain in the public system, both patients and health care personnel consider the Caja to provide extremely high quality health care. The Caja is where patients go for complex, chronic, or emergency medical services, not only because they do not have to pay (beyond their wage contributions), but because the public system is considered the best equipped to handle these problems. The one physician I interviewed who had not worked in the Caja at all said,

In the Caja, those are people who have been trained in the public system and the system has paid for them to be trained. These people are the best
of the best that we have in the country. They have gained their experience in the public sector. It’s not the same thing if you do an open-heart surgery in the private sector, where you do one a year. You do one a day in the Caja. So you become really, really good. (34)

The great majority of Costa Rican physicians and patients work in, and use the Caja, but it has been faced a number of challenges in recent years, which will be the topic of the next chapter. These are not around its technical capabilities, but rather its administration, wait times, and high volumes of patients, which leave little time for physicians to spend with each patient. These constraints have led a growing number of physicians and patients to migrate to the private sector. Although it is rare for a physician to forego training in the Caja altogether, it becoming more and more common as a career trajectory for a physician to work for a number of years in the Caja, gaining experience and expertise, and then move to a private sector practice after they have gained enough experience and established a client base.

**Solidarity as Ideology: Principles of the Caja**

Despite its restrictions, Costa Ricans love the Caja, consider it to be of high quality, and are deservedly proud of its achievements. Participants across this research uniformly praised the Caja’s founding social principles and the underlying belief of the health system—that health is a right—is not questioned. When asked what the best things about the Costa Rican health care system are, almost all participants referenced its social principles:

At the Caja, it doesn’t matter if you are the President, if you are a homeless person. If they need to do a surgery, they’ll use everything. They won’t say, oh no, he doesn’t have money… no, no. We’ll do the surgery. People do not die in the Caja because they don’t have insurance. That’s the thing I love. (38)

In addition to belief in health care as a right, not one person I spoke with
complained about the fact that wealthier Costa Ricans subsidize health care for the poor.

The motto of the Hospital San Juan de Dios, one of the most beloved Caja institutions in the country is “el bien que le hacéis a los pobres lo hacéis a vosotros mismos” (the good that you do for the poor is good that you do for yourself). Some proudly referred to the Caja as a “Robin Hood system,” saying:

The focus of health should always be directed to equity, solidarity, universality, and the focus should be on attending to the person who needs it the most and who has fewer resources. Because we have seen that economic issues are related to health--the less I have, the more probability I have of getting sick. So there will be many more problems in the larger population when we don’t take care of the poor. The health system can’t favor, or lean towards, the elite population. It should work in favor of the simpler population that is in need of services. Those for me are the principles that should always govern us. (22)

The Caja is hailed as the great success of Costa Rica. I heard it called “the pillar of the nation,” and “the mother of Costa Rica,” and credited with keeping the social peace, and, preventing war. A Caja administrator said about the Caja,

This institution makes the difference between us and other countries in Latin America. It gives peace to the country. The wars in other countries—guerilla wars—are because of their social circumstances…they fight because they don’t have health, because they don’t have education. Someone told me that Guatemala spends 30 percent of their PIB [GDP]—30 percent of the income of the country—for the army. Why do you do that? In Costa Rica we spend the 7 percent on health. To give health to the people; and we don’t have war. (45)

Although many had complaints about the deterioration of the social system, citizens still have great confidence in the Caja. A 2004 poll conducted by the UCR asked Costa Ricans about their pride and confidence in state institutions and national values. Those polled said they had more confidence in the Caja than in the justice system, the police, the national government, or the Catholic church (Ackerman 2009). The achievements of the social security system play a prominent role in the story of Costa
Rican exceptionalism. It is an enormous part of Costa Rican national identity and what it means to be Costa Rican.

Today, the Caja continues to dominate health insurance, employment, and health care provision, operating 29 hospitals (compared to 6 hospitals in the private sector) and 940 primary health care teams called EBAIS (Equipos Básicos de Atención Integral de Salud)—an extensive network of clinics located throughout the country. It has more than 48,000 employees, including the large majority of the nation’s physicians (CCSS 2010). Funding for the system comes from mandatory taxation on wages from employers (9.25%), employees (5.5%) and the state (0.25%), and the Caja currently covers about 90 percent of the population (Muiser, et al. 2008).

The Costa Rican Image and the Medical Tourism Blueprint

Our education system, our health care system—they give a certain condition to the country. Sure, you can go somewhere else, to a neighboring country and you can find some good surgeons, but they are not surrounded by the correct system. So if you have unplanned complications, heart problems, or something else, you benefit from the [public] well-developed system of medicine around you. So I think our system is what makes it a safe place for medical tourism. It’s not just about the nice buildings with a lot of luxury, and transportation and hotels… the health system is what makes the difference. (15)

The above quote outlines what a plastic surgeon who frequently works with medical tourists explained to me. It is the successes of the health system that have opened the door for the development of medical tourism in Costa Rica. Costa Rica fits the “blueprint” of the medical tourism industry quite well. It has high quality health care, a skilled workforce, and a large English-speaking population. Since the 1970s, it has grown into a very popular tourist destination, largely due to its image as peaceful, healthy, and natural. It is home to one of five “blue zones” in the world, wherein people live
measurably longer lives, and was named “the happiest place on earth” in a New York Times op-ed piece in 2010 (Kristof).

Costa Rica is particularly well known as an ecotourism destination due to progressive environmental policies and its ownership of a disproportionate percentage of the world’s biodiversity (five percent of the world’s animal and plant species are found in Costa Rica). The national slogan for the Instituto Costariccense de Turismo, (ICT, or the Costa Rican Tourism Board) is Sin ingredientes artificiales (No artificial ingredients) and a more recent slogan focuses on medical tourism, Aquí se cura todo (Here we cure all). These idyllic images of Costa Rica ignore much of the poverty, increasing violent crimes, and unsanitary conditions that exist, but fit perfectly with the ideal archetype of a medical tourist destination.

Figure 8: Slogan of the Costa Rican Tourism Board: “Aquí se cura todo” (Here we cure all). (Instituto Costariccense de Turismo 2011)
It is ironic that the Costa Rican system that invited medical tourism clashes so dramatically with the neoliberal principles of medical tourism. A private hospital administrator thought that the Caja helps to brand the country, making an analogy to grocery shopping:

You are not going to go to a supermarket to buy meat if you know beforehand that the meat that they sell in that Automercado [a national supermarket chain] is a product of cattle that suffers from mad cow disease. But when you have a country that shows good health indicators, a well-maintained public hospital network, presents a well-defined face, or brand, when it comes to health treatment—then the public sector complements the private sector in the sale of health services. It is not that the public sector goes out to sell services and provides services to health tourists themselves, but it is about the face that the Costa Rican state presents and it is a face that complements the [medical tourism] activity that is being developed. (18)

The face that Costa Rica presents to the world, and its exceptionalism within the region, has helped it to become a very popular medical tourist destination, particularly for Americans. However, the health system developments that have allowed Costa Rica to fit the medical tourism blueprint, and emerge as a destination, have been achieved in a very different way than the neoliberal model on which the medical tourism industry is founded. The socialized health care system in Costa Rican system makes it a standout
compared to other medical tourism destinations, which might already be more oriented to private health care provision, or that already have inequitable health care systems.
CHAPTER 4: PRIVATIZATION OF THE HEALTH CARE SYSTEM

Just as the Caja has contributed to the rise in medical tourism, the shift in national priorities towards privatization and global economic development has meant a contraction of the public system that, in many ways, is accountable for this global recognition in the first place. In recent years, there have been significant internal and external challenges to the hegemony of the public system, and private health care is on the rise.

Demographic changes, misuse and corruption within the public system, challenges in managing human resources, and financial burdens—often intensified by the private health care sector—have all contributed to internal strain on the health care system and have affected the ability of the Caja to take care of its citizens. These pressures, along with enhanced opportunities in the private sector—spurred by privatization and medical tourism—have led physicians and other health care personnel to seek employment outside of the Caja, exacerbating the difficulties of health care provision through the public sector.

The Relationship between the Public and Private Health Care Sectors

Multiple times during the course of my research, I was asked why I should be so concerned with the public health care system when I was studying medical tourism, which is wholly in the private sector. I was told that there is no relationship between one and the other; the public and private health care sectors function totally separately. When I asked a medical student about whether medical tourism has any negative impacts for the Caja, he responded sharply:
Private is private. If a tourist comes to have surgery here, it doesn’t have to affect a Costa Rican citizen. He is in a private hospital, he is paying for his surgery, it is income for the doctors, it creates more jobs and that helps the growth of the country. Besides, most of the surgeries are aesthetic, that’s what I understand; so public hospitals won’t get involved in that anyway. It is just private. (37)

Though the relationship between the public and private health care sectors is not a simple one, and may not be readily apparent, I argue in this chapter that this relationship not only exists, but that the two sectors are intricately connected. The physicians and personnel who practice in the public and private sectors are the same; the patients who seek care in the public and private sectors are the same; sometimes even the equipment and facilities used in each sector are the same. Since the inception of the Caja, the private sector’s survival has come to depend on its relationship to the public sector in varying capacities over time. Their relationship is, at best, symbiotic, and, at worst, parasitic—with the private sector benefitting from its position as the Caja shoulders the burden of providing health care to an increasing Costa Rican population with decreasing funds to do so. Privatization in Costa Rica has been more passive than in other Latin American countries (Clark 2010), but it has been occurring nonetheless.

The Role of the Private Sector in Health Care Provision

Contrary to the prominent place that state-sponsored medicine holds in Costa Rican national identity, the role of the private sector in the national health care system has been “more limited, home grown, and pragmatic” (Homedes and Ugalde 2002). This is not to say that the private sector has not had a notable role in the health system historically. There have been several attempts to promote mixed-medicine models, which have been entangled with the Caja’s development. The overt justification for these mixed-medicine programs is to relieve strain on the public system and reduce waitlist times for
patients, though this rationale has been questioned by critics of privatization, suggesting that the true intent is more politically and economically driven (Salas 2009). In particular, pressures by international agencies such as IMF and World Bank, and the inclination of Oscar Arias’ government\(^{17}\) towards privatization, are cited as some of the actual reasons behind increased privatization within the health care arena.

The first of these mixed medicine models occurred in the 1970s when the Caja piloted a *medicina de empresa* program (company doctor program), under which companies agreed to pay the salary of a Caja physician and provide office space, while the Caja provided all necessary testing and medications. Though still used on a small scale today, the program’s impact has been limited. Then, in the late 1970s, the Caja piloted another mixed medicine model wherein patients insured by the Caja paid out of pocket to go see a private sector physician, with the Caja providing any necessary tests or medications. This program is also still used to a limited degree today, but it never really took hold because it “both offends a strong anti-privatization current within the Caja and, because it is based on fee-for-service payments, is too expensive to expand” (Clark 2010).

A more successful venture occurred in 1988, when the executive president of the Caja, Dr. Guido Miranda, under pressure by President Arias, piloted a cooperative model of health care. It was imperative to Dr. Miranda that the Caja not be privatized and that it maintain control over the cooperative. He successfully set up the first health care cooperative in the San José suburb of Pavas, called *Coopesalud*, which was publicly

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\(^{17}\) Oscar Arias was the president of Costa Rica from 1986 – 1990, and, after a Costa Rican law changed concerning re-election, again from 2006 – 2010. He won the Nobel Peace Prize in 1987 for promoting peace within Central America, which was steeped in warfare at the time. He called for more integration in the region and proposed a Central American Parliament during his first administration. During his second, however, he declared that Costa Rica would not join this Parliament. He is regarded as a neoliberal, though he belongs to the social democratic party, *PLN.*
funded and privately managed. This model was deemed a success, and the Caja continued expanding it until the existing six cooperatives were operating in Costa Rica. Four are true cooperatives, one is operated by the UCR Medical School, and one is run by a for-profit doctor’s group called Asociación de Servicios Médicos Costarricenses (ASEMECO, Association for Costa Rican Medical Services), which owns one of the “big three” private hospitals, Clínica Bíblica.

The cooperatives are all located in populous suburbs of San José and serve upwards of half a million users (Díaz 2009). Though obligated by the Caja to provide a package of essential services to the population, they are otherwise free from public laws regarding health care purchasing and management. There is debate about whether or not the cooperatives are more efficient than Caja facilities, and many have claimed that they actually are more expensive to operate than other public facilities. When this issue came to light a few years ago, cooperatives became obligated to undergo a public bidding process in order to gain the Caja’s business. Reports suggest not only that the cooperative model is less efficient than the Caja, but that they refer patients to Caja facilities more than is necessary, creating an undue strain on public facilities (Homedes and Ugalde 2005).

In the early 1990s, another mixed medicine model, the “free choice medical program,” was established allowing users to seek care from a private physician of their choosing (within the Caja, patients cannot choose their physicians) with economic assistance from the Caja. The public sector also began contracting out complex diagnostic testing to Clínica Bíblica, with the official reason of “avoiding technological risk.” This contract has been critiqued as a result of political pressure to create a space for private
medicine within the country and for personal financial gain (Salas 2009). The contract became, in a matter of years, a purchase of millions of dollars on medical equipment that benefitted the private sector. The Clínica Bíblica director told me in an interview that over 20 percent of his hospital’s sales are currently to the Caja (8).

There are many suspicions about the nature of these public–private relationships, and the way that private sector entities like ASEMECO, and Clínica Bíblica “win” these bids. This became national news when Rafael Ángel Calderón Fournier, ex-President and, ironically, son of the Caja’s founder, was convicted in 2004 for his involvement in the largest corruption scandal in the Caja’s history. He awarded a multi-million dollar Caja contract to a private pharmacy chain, the Fischel Corporation, then dispersed nearly $8 million in payoffs to highly ranked Caja officials (Arbol 2009). This notorious Caja scandal is fresh in the national memory, and it has caused other doubts around who wins private sector bids for Caja contracts.

It is apparent that, in spite of the national orientation to public health care in Costa Rica, the private sector has always intervened to some degree in the management and provision of health care, and several policy decisions have allowed for greater private participation over time. In reality, the private sector is sustained by the Caja and public sector contracts to provide services to Caja users. This is an important point to keep in mind as we further discuss Costa Rica’s shift toward passive privatization, the burden that private medicine creates for the social security system, and how medical tourism impacts the public sector. The public–private relationship in Costa Rica is complex, but the two sectors are undeniably connected.
The Private Sector Today

As compared to the 29 Caja hospitals in Costa Rica, there are only 6 private hospitals, the newest of which, *Hospital Metropolitano*, opened in late 2011. The “big three” hospitals where I conducted fieldwork – *Hospital Clínica Bíblica*, *CIMA*, and *Hospital Hotel La Católica*, are popular among American expatriates and medical tourists, and all three have gained JCI accreditation since 2006. *CIMA* (highlighted in the field note excerpt that began this dissertation) opened in 2000 and advertises itself as “ultramodern” and “designed and organized for Americans,” with foreigners comprising over 25 percent of its patients (CIMA Hospital 2012).

Two more private hospitals are slated to open by 2013 in the San José metropolitan area (Arce 2011a), as well as two satellite hospitals of *Clínica Bíblica* and *CIMA* in the Guanacaste area, the most popular tourist area in the country. If these openings go as planned, the number of private hospitals in the country will have doubled since 2011, a shockingly fast growth for such a small country. This does not include smaller clinics, which have been on the rise as well.

Despite this unprecedented private sector growth, the Caja covers over 90 percent of Costa Ricans, and those who are not covered (mostly those who work in the informal economy, the self-employed, or undocumented immigrants) are still eligible to use its services even though they do not pay into the system.

Most locals who access private facilities do so as a limited health care strategy. The low number of private sector users is primarily cost-related, but the Caja is also widely acknowledged as providing the best care available for illnesses and injuries because it will perform every test required and take all necessary medical measures to treat patients, regardless of the cost. For the majority of Costa Ricans, the cost of private
care is too high and the private sector remains out of reach. However, long wait times in the public sector have led patients with financial means to seek care in the private sector, and studies have shown that up to 30 percent of the population now uses private health care in some capacity (e.g., Connolly 2002; Herrero 2001; University of Costa Rica 2006).

Only upper class Costa Ricans and foreigners can afford to regularly receive their health care within the private health care system, but middle class patients use the private sector in a limited capacity—for example, they might get diagnosed within the private sector to avoid a long wait time in a public facility, but upon diagnosis, return to the Caja for treatment and medicines, especially for complicated or expensive care. This results not only in double expenditures for Costa Rican families (who pay for the Caja from their wages, and out of pocket for care in the private sector), but also in a strain on the public health care sector, which performs the most costly procedures.

Internal Pressures on the Costa Rican Health Care System

Demographic Changes in Costa Rica

There are demographic changes occurring in Costa Rica that contribute to a strain on the Caja as well. The population has been growing at a steady rate, while, at the same time, people are living longer. Life expectancy today is nearly 20 years longer than it was in 1960 (Index Mundi 2009). This demographic shift towards an aged population (common to developing and developed nations alike) means an increased demand for health services related to treating chronic conditions, which are often the most expensive.

A growing immigrant population in Costa Rica, mostly Nicaraguans, has also increased the costs of health care. According to the 2000 census, there were 226,374 Nicaraguans residing permanently in Costa Rica, nearly six percent of the total
population (Muiser, et al. 2008). This figure does not include short-term migrant workers from Nicaragua, or those not captured by the census for lack of a fixed address. Nicaraguan immigrants are perceived as a threat because they use the Caja without paying into it. It has been found, despite these anti-immigrant sentiments, that immigrants often do pay into the system more than popular opinion suggests (Téllez 2011), and that it is often their employers who fail to pay into the system (Salas 2009). Immigrants tend to work the lowest paying jobs within Costa Rica, as coffee pickers, banana plantation workers, maids, or guards, and often there take place in the informal economy, or bosses flatly refuse to pay the obligatory 9.25 percent contribution for their workers.

Intensifying violence and poverty within Costa Rica, as well as patterns of global neoliberal consumption (such as an affinity for fast food) have also led to increasingly expensive treatments within the Caja, as obesity, cardiovascular disease, cancers, and other “diseases of affluence” have made their way to Costa Rica (Téllez 2011). Though this consumption takes place in the private sector, the associated medical costs are absorbed by the public sector. In lieu of preventive care, these problems have translated to an increased emphasis on high-tech and intensive medical interventions, which are very expensive for the Caja.

**Threats to the Caja’s Financial Stability**

The Caja is facing serious problems of financial sustainability. All residents of Costa Rica, regardless of their enrollment in the public system or immigration status, are entitled to use Caja services, and anyone who enters a public facility for emergency services will not be turned away, even if they lack the required insurance. The Caja also offers several options for medical coverage. While salaried workers and their employers
pay a portion of their monthly wages into the Caja, if a household income depends on that single worker, then the entire family receives insurance from these contributed fees. Contract workers are free to enroll in the Caja, paying a monthly flat fee that varies according to the worker’s income. The government pays for students and those living in extreme poverty.

These enrollment options comply with universal health coverage under the constitution, but make the system difficult to regulate, and it is quite easy to get around paying the enrollment fees. The Caja has had difficulty collecting mandated fees, particularly from the self-employed or those not employed in the legitimate economy, and audits of the Caja’ collection system showed significant problems of contribution evasion and delinquent payments. In 1998, it was estimated that about 30 percent of the Caja’s annual income was lost due to evasion, which does not take into account the growing problem of late payments (Muiser, et al. 2008). A medical student told me,

They [the Caja] should make everybody pay, but they cannot. Before, everybody paid into the Caja, so that made health care available for those who couldn’t pay for it. But now, a lot of people dodge the system and don’t pay the Caja. So the poor people who use the most resources can’t pay, and the wealthy people aren’t paying into the system either, and we end up with a system that has no money and still has to cover a big part of the population. (43)

In addition to many citizens not paying into the system at all, it is not uncommon to find instances wherein someone will wait until they are diagnosed with a serious or chronic illness and then enroll in the Caja to receive expensive treatments. The system is structured in such a way that if a citizen begins paying for Caja insurance today, he or she can begin receiving services tomorrow, regardless of health status or cost of the services.
Patients and physicians alike occasionally find ways to manipulate the long waitlists for procedures that impact the system. Patients might put themselves on more than one waitlist for the same procedure—which is possible because there is no centralized tracking system to monitor the lists—thus decreasing the efficiency of the system.

Physicians, especially specialists, who manage their own patients’ waitlists, sometimes abuse the system too. For example, they might take patients out of turn because of personal relationships, or accept bribes, known as biombos (this literally translates into a “folding screen”), in exchange for moving a patient to the top of the list. Biombos occur across public and private sectors due to the fact that many physicians work in both sectors. For instance, a physician in the private sphere might accept a biombo from a private patient to push them to the top of the waitlist in a Caja facility. In these cases, the patient benefits by not having to pay for expensive private services and avoids the long wait times for treatment in the Caja, while the physician makes extra money “off the books.” Occasionally, a reverse strategy might be used, wherein physicians “harvest the patients from the public sector, and bring them into their private office where they can charge them” (34). These tactics work because, as one economist I interviewed pointed out, it is not only the doctors who move between sectors, but the patients too:

As a physician, you are hired by the Caja, but at 3:00 when you finish your day [in the public sector], you go across the street to your private office. And your patients in one sphere could be the same patients as in the other. And then…well only angels will keep good accounting of the situation. (14)
Caja physicians have occasionally been known to use another strategy to increase their public salaries wherein they perform fewer surgeries during their scheduled 7am to 3pm work day and then schedule procedures after hours, during which time they receive overtime pay.

**Unnecessary Patient Referrals to the Caja**

Within the Caja, access to the health care system should theoretically be through the primary level of care; however, users of Caja services may, and often do, opt to go straight to a Caja hospital rather than use a primary care facility first. In addition, the EBAIS primary care clinics and the public–private cooperatives tend to refer patients to Caja hospitals more than is necessary (i.e., when they could instead be treated on an outpatient basis or within the clinic). This contributes to extremely high patient volumes in the Caja hospitals. A private sector physician said,

> Here, everybody tries to get to the hospitals. There are three Class A hospitals, and in these hospitals, everybody comes in with just a cold… the structure—the system of EBAIS that we have now—that doesn’t work. All the doctors end up sending the patients to the hospitals. I mean they don’t have resources to work with at the EBAIS. The resources should be with the EBAIS, in the primary care clinics. So they have everything they need to solve problems. And the big hospitals should dedicate to more serious illnesses. But that’s not the way it works here. Here, if you are in the emergency room at a hospital, you’ll see diarrhea, toothaches, colds, everything. So the emergency rooms get saturated and then the hospital collapses because it doesn’t have the capacity. (33)

Often, the municipality pays for the provision of primary health care while the state government pays for hospital care. There is a tendency among first level physicians to unnecessarily refer patients to the second level of care to diminish their own workload and reduce the expenditures of the municipal unit. More than 43 percent of the services
provide in the public health sector are hospital services, compared with 11.1 percent in the private sector (Herrero 2001).

Evaluations of the public–private cooperatives have suggested that this model is actually less efficient than the Caja, and more costly without evidence of improved quality (Homedes and Ugalde 2005). The cooperatives receive a capitation payment from the Caja for their services, but the Caja provides all necessary tests, specialty care, hospitalization and medicines. Residents in the selected geographical areas join the cooperatives at no cost, but continue to use the Caja for all non-primary health services and emergencies. The evaluations also indicate that there are more referrals to public hospitals, not because of medical need, but as a way to reduce the cooperatives’ expenditures and physician workloads (Homedes and Ugalde 2005). This increases costs and workloads of the Caja, and reduces the overall efficiency of the Costa Rican health system. Surplus profits of these non-profit cooperatives are distributed mostly among physicians and other staff members (Homedes and Ugalde 2005), rather than supporting the Caja.

Private hospitals, too, often refer patients to the Caja for the most complicated or critical surgeries. Private providers typically make these referrals because a patient can’t afford to pay for the treatment, the procedure is not considered profitable, or because they want to avoid high death or complication rates that might put off the rich patients and foreigners they are targeting for business.

Beyond these referrals, patients (even the wealthy) also just prefer to use the Caja for chronic illness and for complicated procedures. A professor at UCR said,

Except for the waiting lists, public health care is good. It is even sometimes better than private care. It’s recognized across the continent,
and the specialized care is fantastic. Even the rich people will stay with the Caja because of that. You know, they might go to the private ambulatory services for a delivery [birth] or a cesarean section, or something cheap, like a small operation—a knee thing or something that is not a huge thing—they will do it in the private sector… but if they really have cancer or something serious they go to the public sector, to the Caja. (22)

This means that the highest number of patients and the most expensive procedures and treatments all remain within public hospitals, placing a heavy burden on the system. As a result of all of these factors, revenues entering the Caja tend to be less than the benefits paid out. This is a problem that has become more severe over the past decade. As of February 2010, the Caja, had accrued an $82 million deficit (the annual budget totals $1.8 billion) and owed $46 million in overdue payments to service providers and medical equipment suppliers (Téllez 2011). Ironically, the central government itself is consistently in arrears on the quotas that it owes to the Caja (0.25 percent of salary per worker plus 9.25 percent for its own employees) and, in 2011, it owed the Caja $220 million (Téllez 2011).

**National Management of Human Resources**

The management of human resources has also been a challenge for the Caja in recent years. In 2004, to address the mismatch between the high numbers of graduating physicians and the low number of residency spots, the government signed an agreement to gradually double the number of residency spots, increasing available positions by 50 per year from 350 in 2004 to 700 in 2007 (Clark 2010), which remains the current number. This occurred under the Arias administration, which, like the current administration, is known for an inclination towards privatization and promoting global industry. This agreement was intended not only to better fill the needs of the Caja, but also to produce physicians for the private sector to bolster its capacity. Despite this
relatively sharp increase in positions, medical students and residents with whom I spoke still criticized the Caja’s long-term management of residencies, saying that it often “goes to extremes,” with Caja opening several positions at once when they see a need in a particular specialty, and then not opening any at all the next year (43).

The difficulty in getting a residency and dearth of available positions is paradoxical because within particular specialty areas there are extreme shortages within the Caja. One explanation for this could found in the example mentioned in the previous chapter, wherein four neurosurgery positions were not filled because no one passed both tests to become a neurosurgery resident. But another reason for these shortages is because the planning area of CENDEISS, which calculates the annual needs of the different specialty areas for the Caja, makes the assumption that upon completing their residency, the specialists trained in the Caja will stay there to practice medicine. While this was the case for many years, and is still the case for many specialties, the number of physicians who migrate to the private sector shortly after their residency has increased sharply over the past decade or so. The most notable example of this was anesthesiologists, who “left in droves for the private sector” (23). In 2009, the extreme shortage of anesthesiologists stopped operations within the Caja. Though this is the most widely used example of a specialty shortage due to flight to the private sector, there are more specialties that are beginning to show signs of a similar pattern, especially plastic and aesthetic surgery (though these are still private-sector-dominated specialties). Sarah Ackerman (2009), in her study of plastic surgery tourism within Costa Rica, noted that most of CIMA’s mid-career plastic surgeons resigned from state employment shortly after completing their training in reconstructive surgery, to the disappointment of their mentors. Private sector
migration is becoming more common in emerging tourist specialties as well—including orthopedics, radiology, urology and pathology. Many physicians I interviewed were concerned that, with more patient volume in the private sector, these types of specialist shortages within the Caja would become very severe.

**The ‘Contrato de Aprendizaje’**

In 2004, to better fulfill the needs of the Caja, and to combat outflow to the private sector—at the same time that the additional residency positions began to be opened—the Caja instituted a *contrato de aprendizaje*, or a traineeship contract, with medical residents. In exchange for subsidized education and training offered by the Caja during their residency period, residents were required to sign a contract stating that they would serve three years in the Caja for each one year of residency training that they had received. These years of service could be carried out in any public facility, anywhere in the country where the Caja needed them. This essentially meant that new specialists would serve a minimum of nine years wherever they were sent. If they failed to fulfill these terms, they would be required to pay a fine of 32 million colones (approximately $64,000) to be released of this commitment (CCSS 2004).

The contract did not apply to those who were already enrolled in a residency, so the first cohort of physicians to whom the terms applied graduated in 2010. Most residents felt that it was fair to give these years of service to the Caja upon graduating, and that it was their social responsibility to do so. However, when the first cohort of specialists graduated, things began to go badly. They were sent to assigned posts throughout the country, including very remote and rural locations. While this was stipulated in the contract, the decisions about where each physician would be sent were
supposed to be made through a series of transparent criteria, but in practice seemed to be more political in nature and lacked clear justification for why residents were being sent to these locations. In some cases, the clinics where residents were sent lacked resources (either technological or human resources) to practice their specialty. One surgeon told me that he was sent to a remote community clinic where there was no anesthesiologist, and so he was unable to perform any surgeries that he had been trained to do (37). This is also an important time in the life of graduating physicians, when they are starting to marry and have families. The placements sometimes split up family members or couples, moved physicians to places that were considered dangerous, or that lacked sufficient education and health services that are conducive to raising a family.

In general, the problems with the *contrato de aprendizaje* are political or administrative, and not because doctors either want to practice in private sector or do not want to practice in the public sector. Young physicians overwhelmingly recognize that they need to work in the Caja in order to continue learning and in order to have enough patient volume to improve within their specialty. That said, there are some who choose to leave for the private sector and view this contract as an alienation of their right to do so. Karina and I heard accounts of physicians who, to avoid an undesirable placement by the Caja, finished their specialty training, took out loans to pay the contract’s sanction, and then left the Caja to practice in the private sector where they could recoup the costs of the fine more quickly. This is a rare response, however. Most newly formed physicians—coming from public university where their education was subsidized, and fresh out of their residency in Caja, where they did not earn much money—are not used to saving much money, and the prospect of paying the 32 million colone sanction is downright
impossible.

The 2010 Residents’ Strike

On June 14, 2010, 900 medical residents went on strike with the support of the Unión Médica Nacional (National Medical Union) and the Sindicato Nacional de Médicos Especialistas (National Union of Medical Specialists or SINAME). The only demand of the residents was that the Caja abandon the traineeship contract, claiming that there are “no other jobs where one must take on a debt to work” (Long 2010b). After several days, the two unions called for its members to join the strike as well, adding an additional list of demands for improved equipment and working conditions.

The strike lasted 13 days before a compromise was reached. The Caja lowered the contrato de aprendizaje requirement for graduated specialists to work anywhere in the country, from three years to one year for each year of residency. The new agreement also replaced the 32-million colone sanction with an eight percent contribution from the resident’s base salary, which remains untouched for the duration of their residency with the Caja. If the resident completes their term in the assigned position, they receive all of the money back. If they opt out of the agreement, the fund remains with the Caja.

Although a compromise was reached, this solution significantly impacts the ability of the Caja to fill rural positions, particularly in undesirable areas, which often have the most need. It also is demonstrative of general dissatisfaction with Caja, as well as emerging ideas of individual choice that are contrary to the image of physicians as public servants to the people. Furthermore, it highlights an erosion of health care achievements in particular areas of the country, and an increase in violence, drugs, and poverty that makes these locations undesirable to live.
Deteriorating Conditions in the Caja

These pressures on the public system have led to a deterioration of conditions within the Caja, for both patients who use the system, and health care personnel who work there. Patients most often complained about the long wait times for appointments within the Caja (which can be longer than a year), and the impersonal way that they were treated (patients are typically allowed to spend only 15 minutes with physicians). Physicians thought that these conditions were extremely frustrating as well. An administrator of Hospital San Juan de Dios, a landmark within Costa Rica, and once called the crown jewel of the Caja, told me,

Here is what is happening at this moment in our hospitals. In January of this year [2010], I had a waiting list of 8,600 patients. Total—in all specialties. Something that we did in the past that motivated our employees, economically, was that they would stay after 4pm and do night shifts, and they made more money. And, for me, it resolved about 250 patients a month from the waiting list, so 3,000 per year. So this year, I have tried to have them [Caja administration] to give me the night hours again, and there is no money, no budget for that. So I started with 8,600 patients on the wait list in January. In August, I had 10,800. And in December I will have 12,000.

So the administration then demands that I open more consultations to take care of the wait list. So I open more consultations, and they demand more from the people who work here, so they give more, but with the same resources. Do you know what they do? They leave! The anesthesiologists, the nurses, the doctors, they all prefer to go to a clinic where they can be calm and can work in peace. That is not here [in the Caja]. They just leave…and whoever can leave without fulfilling the contract [contrato de aprendizaje] because he doesn’t have a need for this, goes to the private sector. They don’t want to be here… I mean, how can we retain them? (42)

Many expressed a desire to eventually acquire enough clients to be able to leave the public sector altogether and move into the private sector, where they could earn a significantly higher salary and have more control over their time. A physician working for the Caja might make somewhere between $1,500 and $3,000 per month, which they
can supplement by being on call or working additional shifts. A plastic surgeon or orthopedist working in the private sector might make up to $10,000 for one surgery. A couple of private sector surgeons whom I spoke with told me that with just one in surgery their private practice, they are able to earn the equivalent of an entire month’s salary from the Caja. While this is not the case for all specialties, specialists told me that they could make at least four times more in the private sector, if they are able to keep enough clients.

Within the Caja, physicians are paid the same base salary regardless of the number of surgeries they complete, while private sector physicians are paid per surgery. Because of the tenure system in the Caja, it is possible to make a very high salary, but typically not until later in the physicians’ career. Not all specialties are so lucrative in the private sector, and several physicians enjoy the stability and benefits that come with their Caja positions, as well as the lack of personal responsibility. For example, one private sector orthopedist told me,

We earn more money outside the social security system. A lot more money. But we have more responsibility with our patients. And the doctors that don’t want to work privately it’s probably because of that. If you do a surgery 8am in any Caja hospital and that patient starts to bleed at 10pm, there is another doctor that is going to see him. In the private sector, no, you have to wake up and go see the patient. (9)

The current condition of the Caja, as well as global pressures on the system to change (which will be discussed in Chapter Four) have led to disenchantment among citizens with the Caja. The social ethic on which the system was founded is eroding, and middle class Costa Ricans and physicians alike no longer have the buy-in that they once had in the collective system. Physicians in the Caja are thought to work “for intrinsic motivation, while in the private sector they work for money” (22). Many feel that the Caja is being “taken over” by the poor, and by foreigners who do not pay into the
system\textsuperscript{18}. There are still physicians who remain in the Caja because they feel that it is
their social responsibility to do so. An administrator at Hospital San Juan de Dios said
that,

> Working in the Caja is difficult. But I like to work for the social security. I
> feel good, and productive when I give to people who don’t have money,
> and give them an opportunity to have health care. Even if I could make
> more money elsewhere, I would stay. I know if I went to private practice, I
> probably would have a lot of money. I don’t know, I think the money is
> not important. But some people say, you have to work to live and not live
to work. (45)

The benefits of remaining in the Caja are becoming fewer, while employees are
asked to do more with diminishing resources. I heard several times that “the Caja is
broken,” or that “it needs to change.” But throughout the research, no one told me that
they wanted the Caja to disappear altogether, and there was a great deal of concern over
the future of the public system. An older \textit{ama de casa} (housewife) surveyed at
\textit{Coopesalud} said that she used the Caja nearly 15 times for her medicines, surgeries, and
treatments for the H1N1 flu that she had last year. She tries to never use the private
sector because “there are too many money needs at the house” and wrote in an open
comment section, “I don’t know what we would do without the Caja.” Disenchanted
patients and employees alike know that Costa Rica needs the Caja. It keeps the social
peace, gives access to those who would not be able to purchase care in the private sector,
and represents the solidarity of what it means to be Costa Rican.

\textsuperscript{18} In this case, the patients were referring to immigrants from Nicaragua and other parts of Central
America and the Caribbean. Those surveyed and interviewed made an interesting distinction
between medical tourists as foreigners using the system, and immigrants as foreigners using the
system, which will be examined further in the Chapter Six.
Figure 10: At left: the former “crown jewel” of the Caja, Hospital San Juan de Dios, with patients waiting outside. At right: an EBAIS primary care clinic. (Photos by author).

**Working in Both Sectors**

At the time of development of the social security system, it was agreed that physicians who work for the Caja would also be able to practice in the private sector—a concession to the private physicians who were so adamantly against the development of the social security system. From the outset, physicians have protected their right to practice in the private sector, and at the time that the Caja was established in 1941, the key components of their contract with the state included “clinical autonomy, unfettered opportunity for private sector practice, guaranteed decent wages, and well-stocked hospitals” (Clark 2005).

This further muddies the public–private relationship in that many physicians who practice full time in the Caja also work in the private sector after their workday in the public sector is complete. There are no laws or restrictions against doing so, and this is popularly viewed as a kind of compromise—wherein physicians are able to supplement their salary and the Caja is able to retain their physicians while paying them less. It is a way to “live in the best of two worlds,” as one participant put it (14). They begin by opening a private office where they can work a couple evenings per week after their work day (7am–3pm) is complete, and then gradually expand their hours in the private practice.
until they can maintain enough clients in the private sector to make the move permanently, and leave the Caja. In the past, most physicians and nurses did not have this option because there was not a high enough patient volume in the private sector, but with increasing privatization and the establishment of medical tourism, this is changing. A physician who had chosen this career path and moved full time into the private sector after years of working in the Caja told me,

   When you are beginning and you need to learn, to have more training, you can only do that in the social security system, because they are teaching hospitals. That’s the reason. And later, when you have the experience… well then we use that experience in private practice. (29)

In the early 1990s, approximately ten percent of health professionals worked in the private sector; by the late 1990s, this proportion had risen to 24 percent (Connolly 2002); today, it has been estimated that at least a third of the nation’s physicians have a private practice (Ackerman 2009). The medical director of Hospital Hotel La Católica told me that of 105 doctors at La Católica, only 38 of them do not also work in the Caja, and of those 38, most are retired from the Caja, or voluntarily left to dedicate exclusively to private practice. The majority of those who voluntarily left were orthopedists because there are enough clients for them at La Católica. He continued by saying that that for other specialties, like neurosurgery, cardiovascular surgery, or pulmonology, it would not be profitable enough for the physician to live only off of only their private consultations (because patients use the Caja for those procedures), and so these specialists tend to split their time between the Caja and La Católica. The flow of physicians is almost always
from the Caja to the private sector, and not the other way around. As one nurse put it, “the link between the public and private sectors is always the doctors” (41). The physicians who work in both sectors tend to be the best physicians in the country within their specialty. If they were not, they would not be able to attract enough patients to make a living in the private sector.

**Passive Privatization**

While the connections between the public and private health care sectors in Costa Rica may not be straightforward, the two sectors have a complex and convoluted relationship that, at times, has stemmed from overt historical, political and economic decisions, and, at other times, has occurred without purposive intent. As private facilities and hospital groups, foreign investment in health care, and the number of middle-class Costa Ricans using the private sector rapidly grow within Costa Rica, state-sponsored health care is slowly contracting. A physician who was instrumental in the resident strike said to me,

> There is a trend occurring here that Caja has less every time. Before, in a Caja hospital, the cleaning staff, maintenance staff, the doctors, nurses, laundry people—they were all employees of Caja. Now, the laundry service is not from Caja, it is privately managed. Cleaning services are not from Caja, there are sub-contracted from a private company. The people that make repairs are not from Caja anymore. And some want to take it even further, and maybe Caja won’t have doctors or nurses or anything, only infrastructure so they could hire people to go and operate there. This doesn’t make much sense to me, but it would not be so harmful if we had faith that everything was being done in a transparent way, but when you see how bids are made [for public contracts], they are not done in a fair way. It is their [administrators] friends who are benefitting… and this all means higher expenses for social security than having employees directly hired. I think this is related with neoliberalism, with this new ideology.

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19 Interestingly, this is not the case for nurses, who do not earn a significantly higher salary in the private sector, and tend to prefer the stability of public sector employment. Jobs are much less stable for nurses working in the private sector.
In general, despite the fact that most Costa Ricans are upset about the deterioration of the Caja, they do not connect the deterioration of the Caja to privatization. Many Costa Ricans do not fully understand what privatization is. A medical resident said, “We don’t know what private medicine is. Making a Tico understand it is very complicated... we don’t know what it means to pay for health” (36). Similar to studies of health citizenship that have taken place in Cuba, it seems that a new kind of contradictory Costa Rican is forming—“raised socialist, wants to be capitalist, but doesn’t know what capitalist is” (Brotherton 2003).

The tendency of Costa Ricans to view the public and private spheres separately, as was discussed in the opening of this chapter, aids in the “passive privatization” (Clark 2010) that has been occurring. The separation of the two spheres is entrenched in neoliberal discourse, which rejects public sector intervention in the private sector, and considers the market to function entirely on its own, unencumbered by state intervention. Many whom I spoke with adamantly maintained this belief that “the private sector lives on its own” (4). Perpetuating the discourse that the public and private spheres are completely separate has allowed the private sector to take from the public sector without giving to it. Denying a connection between the two sectors has also meant less guilt on the part of health care personnel and patients, who believe that their decisions to practice in the private sector, to use the private sector for health services, or to evade paying into the Caja are matters of individual choice that do not impact the health care system.

The denial of a public – private connection also means that the problems with the
system are situated firmly within the Caja, rather than on outside forces that impact the system, or on the parasitic relationship that the private sector often has with the Caja. This framing disconnects private expansion from the contraction of state services, allowing privatization to creep into the public domain rather unceremoniously. At the same time, the private sector while evades any responsibility for declining health conditions and increasing inequities that are occurring in Costa Rica. The maintenance of this divide, while not intentional, supports neoliberal forces that are pushing down on the universal health care system and contributes to the vulnerability of the public sector to privatization.
CHAPTER 5: NEOLIBERAL PRESSURES ON THE HEALTH CARE SYSTEM

Although the blame for the current shortcomings of the health care system is often placed on the Caja itself, the rapid privatization that is occurring in Costa Rica is not exclusively due to strains on the system from within Costa Rica’s borders. In fact, many of the burdens on the Caja discussed in the previous chapter originate outside of the country. External pressures on the system, particularly global neoliberal influences that have been prominent forces of globalization over the past decades, have gravely affected the ability of the Costa Rican state to deliver health care to its citizens. In this chapter, I examine the external neoliberal pressures on Costa Rica’s health care system that have left the public sector vulnerable—in particular, Structural Adjustment Programs, Free Trade Agreements, and the spread of neoliberal expectations within health care. These global impositions have left the contemporary Costa Rican state at a crossroads – on one hand clinging to the social principles upon which the nation was founded and, on the other, struggling to find a place in the global economy.

The Principles of Neoliberalism

The medical tourism industry is deeply entrenched in neoliberal ideology. Neoliberalism is “a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade” (Harvey 2005). Privatization, deregulation, and commodification are key principles of the neoliberal agenda, with the end goal being economic development. Under neoliberalism, the role of the state is merely to support private enterprise, rather than to regulate or protect its citizens. Using this model, all sectors of
the economy are to be operated for economic profit, including those that are tied to social welfare, like health care provision. This is due to the assumption that markets are self-regulating and create responsible and rational individuals who are self-governing because they have internalized the hegemonic market logic (Foucault 1991). Neoliberalism governs through freedom and personal responsibility (Rose 1999). Under neoliberal governmentality, the state retreats from direct protection of its citizens and instead attempts to form them into rational consumers through the logic of the market.

In neoliberal discourse, GDP growth is seen as the primary vital sign of a healthy economy and the best proof that society is “developing.” This assumption that economic growth brings prosperity and better life for us all is widespread, and has remained largely unquestioned and unquestionable (Kim, et al. 2000). This is the argument most often cited by proponents of medical tourism—that the industry will bring economic prosperity through boosting the tourist sector and its contribution to the GDP, and that prosperity will then “trickle down” from the top, eventually reaching the poor. This pervasive view assumes that medical tourism brings economic growth, that any economic growth is good growth, and that this prosperity will positively affect all segments of the population. The slogan for medical tourism: “First World treatment at Third World prices21” (Gupta 2004) exemplifies reliance on a neoliberal model that is centered on profit motive.

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20 I am using Gramsci’s concept of hegemony (Gramsci 1971) here, in which ruling class interests become accepted as common sense by the subordinated classes, and the values of those in power become internalized as “normal.” It is an unconscious, deeply penetrating force that is absorbed uncritically and leads to moral and political passivity and the maintenance of the status quo.
21 This was one of the first slogans for medical tourism, but the industry has ceased using it to avoid giving the impression that there is anything “third world” about the medical tourism experience (Turner 2007).
In an era of globalization, wherein individual lives, at a local level, become affected by economic, political and cultural forces at a global level, local concerns become deeply intertwined with national and global discourses (Appadurai 1991). The spread of neoliberalism globally is tightly linked to the Structural Adjustment Programs (SAPs) of the 1980s and 90s, which were shaped by the dominant industrialized nations of the world. These loan programs made neoliberal reforms a condition for developing nations to receive money to rebuild their economies, which had crashed during the global economic crisis of the 1980s. Its spread is also tied to the instituting of global free trade agreements that allowed trade goods to flow freely across international borders and gave precedence to the global marketplace over domestic markets. These neoliberal reforms were intended to improve health care systems of debtor nations, but in fact caused them much harm (e.g., Castro and Singer 2004; Farmer 1999; Janes and Chuluundorj 2004; Kim, et al. 2000; Labonte 2004; Navarro 2007). Neoliberalism has tended to benefit the dominant global powers and their corporate interests at the expense of debtor nations, especially impacting the poor of these nations.

Impacts of Structural Adjustment Programs on Public Health

SAPs in Latin America

The economic crisis of the 1980’s hit the Latin American region hard, resulting in significant intervention by the World Bank and International Monetary Fund (IMF). It was at this time that the World Bank began to play a prominent role in international health policy, especially in developing countries. By the end of the 1980s, the World Bank had become the largest international health lender, setting the course for health
system reform in Latin America and around of the world; these reforms would have lasting consequences (Homedes and Ugalde 2005).

SAPs, based on the neoliberal economic principles described in the previous section, were implemented throughout Latin America to correct what was seen as the failure of social welfare states. The loan terms laid out measures to be taken to transform welfare states into more streamlined and efficient entities in order reduce the large public debts that governments had accrued. Whether or not states should be transformed was never questioned. The key elements of these policies were decentralization and privatization, which were viewed as the only means to increased productivity and efficiency of the state. This translated into a drastic reduction in public sector spending and cuts to the social welfare programs that constituted a large part of public expenditures in Latin America.

Although the decentralization component of the loans was somewhat more successful in the region, only a few countries in Latin America even partially privatized the management or delivery of their publicly financed health services. To some extent due to historical orientation toward social medicine, the majority made less radical reforms by increasing private sector involvement in health care through contracts with the public sector (like Costa Rica’s mixed-medicine models), or in other ways, rather than completely privatizing these services.

The level of adoption of neoliberal reforms in the health care sector has not been uniform throughout Latin America. Chile and Colombia, for example, followed the neoliberal reforms most closely, dismantling existing social security programs and privatizing health services during the SAP reform period. Chile, in particular, had a
health system that was considered one of the best organized and most comprehensive in the region (prior to a 1973 coup) and in fact, the Costa Rican social security system is based on the Chilean model. Chile was the first country in Latin America to implement neoliberal economic reforms, due to strong connections with the University of Chicago, a stronghold of neoliberal thought at the time (Harvey 2005). Chile set up a system of private health insurance providers called *Instituciones de Salud Previsional* (ISAPREs). Today, Chile is one of the wealthiest Latin American nations, but only 22 percent of the population is enrolled in ISAPREs and those who are enrolled pay out 43 percent of the country’s health expenditures (Homedes and Ugalde 2005). In other words, there are high health care costs, high income inequality, and low access to health care.

Colombia followed the SAP blueprint very closely as well; it has been called a “living laboratory” to test neoliberal reforms (Abadía-Barrero 2012). During the SAP period, Colombia universalized a package of mandatory health services, which were administered and delivered by the private sector. After some initial success with this, there were a dramatic increases in health expenditures, which rose 178 percent between 1984 and 1997 due to bureaucratically complex payment and coverage systems, and yet it still failed to cover a large percentage of the population (Homedes and Ugalde 2005). Studies show that the reforms have driven the country into a major public health crisis (Abadía-Barrero 2012).

**SAPs in Costa Rica**

The strides that had been made with the Caja and a strong social welfare state in Costa Rica were put to the test during the “lost decade” of the 1980s (Edelman 1999).
Costa Rica initially resisted the terms of SAPs, but the government eventually had little choice but to conform to the loan conditions in order to receive financial relief for its ailing economy. The proposed reform program for Costa Rica focused on decentralization and the transfer of services from the public to the private sector. Because public and private sector health care providers are the same in Costa Rica, this transfer would mean not only a move of services from one side to the other side, but a move of the workers who provide the services as well. The reform program also focused on expanding primary care and separating the purchaser and providers of health services, which were both the Caja. A new system was proposed, in which the hospitals, rather than the Caja, would be responsible for hiring and firing their own personnel, and would handle the purchase of services and technology. The Caja would then evaluate performance of the hospitals and reward or penalize them accordingly. Hospital authorities, labor unions and the Caja administration flatly rejected this proposition.

Instead, Caja administrators took advantage of the non-specific SAP guidelines on how these transformations were to take place, and opted to focus almost exclusively on the element of expanding primary care. The primary health care system was overhauled and reorganized, and primary health teams (EBAIS) were placed throughout the country so that services were distributed more equitably. This was the major accomplishment of the reform period in Costa Rica.

Beyond this restructuring, there was a general lack of interest in reorganizing and decentralizing health system management, and Costa Rican authorities weighed heavily on the side of equity over efficiency in their compliance with the structural adjustment

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22 The first two IMF loan agreements, in 1980 and 1981, were cancelled due to government noncompliance with austerity measures (Taft-Morales 1991).
loans. The World Bank admits that decentralization of the Caja did not succeed in Costa Rica and reported that its efforts had been “undermined by internal opposition” (World Bank 2003). Compared to other countries in the Latin American region, Costa Rican reforms showed relatively weak commitment to the neoliberal-inspired SAPs. Essentially, Costa Rica took what they wanted from the reform and left the rest. As Clark stated “the long-term dominance of Costa Rica’s centralized state health care system, rejection of radical or neoliberal reform, and dependable focus on equity goals makes it an outlier compared to other Latin American models except for Cuba” (2010). Caja authorities took the opportunity to improve some aspects of public health care delivery during this time, but the popular and political support for the Caja never wavered, and its principles were never questioned, despite outside pressure to privatize.

In Costa Rica, attempts to privatize the Caja and other state entities have consistently met with strong popular resistance and collective action (Edelman 1999; Palmer 2003). In Edelman’s (1999) account of a 1988 peasant uprising in Costa Rica, he documents a “campesino movement” in which small-scale farmers went on strike over IMF, World Bank, and USAID agreements that harmed local agriculturalists by dumping a large amount of inexpensive staple foods into the Costa Rican economy during the Sandinista Rebellion in Nicaragua. A leader of the University of Costa Rica told me,

I feel that Costa Rica really is privileged in the sense that we haven’t succeeded in being "arm twisted" as they [international aid organizations] twisted arms in Colombia or Chile or Nicaragua or El Salvador or Guatemala—with the World Bank trying to sell us imported models from outsiders, saying these models are better than our national model. We have built our own model of health service and have been expanding the coverage of the service and through a single institution. We are one of the only countries in Latin America, perhaps in the world, that has a single public provider of health services, truly public. (7)
Because the state has contributed so enormously to economic and social progress, the consequences of neoliberal reforms, which represented the undoing of the state, and a shift from a statist to a market economy, were especially dangerous in Costa Rica. A founder of the Caja said about SAPs, rather sarcastically, “Curiously, we had already universalized our health care without 240 million in loans.” He continued, “and when you go the route of less state and more market—this means commercializing health and losing all that we have succeeded” (8). This popular resistance to outside pressures and forces of neoliberal globalization makes Costa Rica an interesting place to examine the effects of an industry like medical tourism, firmly entrenched in neoliberal principles.

**Impacts of Trade Agreements on Public Health**

From the same roots as the World Bank and the IMF, the current structure of international trade agreements and the World Trade Organization (WTO) evolved. The WTO, as well as global and regional trade agreements, such as the General Agreement on Trade in Services (GATS), the North American Free Trade Agreement (NAFTA), and the Central American Free Trade Agreement (CAFTA) serve the express purpose of removing restrictions on cross-border trade. These agreements encourage private investment and deregulation for a wide spectrum of services and often supersede national laws and regulations, including those that govern public health.

GATS, a 1995 WTO trade agreement, liberalized trade in services. It has a built-in component of “progressive liberalization,” meaning that countries under the agreement

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23 The establishment of the General Agreement on Tariffs and Trade (GATT) resulted from the Bretton Woods Accords after World War II, from which both the World Bank and IMF were established. The goal of GATT was to stimulate economic development after the war. The loose set of agreements under GATT would later be replaced by the World Trade Organization (WTO) in 1994.
can only liberalize more services, but not less. Essentially, once a service has been liberalized, there is no way to reverse it without paying a sanction. These sanctions are a set amount, rather than a percentage or sliding fee scale, which means that poorer countries are penalized more than rich ones (Labonte 2004). The primary concern about GATS is that it will lead to increased privatization of essential public services like health care. Globally, about 30 percent of all economic activities are government-provided public services, most of which are considered essential services, meaning that there is always a market for them. This makes them attractive to private investors because essential services are safe investments; in 2004, services accounted for 60 percent of all foreign direct investment (Labonte 2004). Medical tourism is considered “trade in health services” under GATS, within the second of four service modes—consumption abroad—wherein individuals utilize a service in another country.

The North American Free Trade Agreement (NAFTA), and the Central American Free Trade Agreement (CAFTA) also serve the purpose of liberalizing cross-border trade. Under these trade agreements, there have been several documented legal cases in which the rights of a multi-national corporation have prevailed over the rights of a national government, even when domestic health was endangered.  

The Agreement on Trade-Related Intellectual Property Rights (TRIPS), while not a free trade agreement, protects intellectual property rights, almost all of which are held by companies in developed nations. It requires WTO nations to protect patent rights for

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24 For an account of the impacts of various free trade agreements on public health care provision, see Shaffer et al. 2005. This article also contains examples of legal actions under international trade agreements, wherein corporations have successfully sued national governments for damages due to impeding free trade, even in cases where the trade good in question clearly threatened the receiving nation’s population health (for example toxic waste, hormone treated meat products, or the use of generic medicines).
20 years (although developing nations have an exception until 2016). The most fervent debate about TRIPS within the public health arena has been over access to medicines. The agreement has caused drug costs to increase dramatically, decreasing access for poorer nations; in particular, access to anti-retroviral therapies (ARTs) has been a topic of much debate in discussions over TRIPS’ impacts. TRIPS reduces access to generic medications in developing countries, a topic that will be discussed within Costa Rica in the next section.

Under these agreements, governments face a loss of sovereignty in policy-making decisions pertinent to human services (i.e., health care, water and sanitation, energy, education), which are treated as commodities like any others subject to trade rules. Such agreements have caused the state, so central to health care within Latin America, to be displaced and have “transformed the capacity of governments to monitor and to protect public health” (Shaffer, et al. 2005). This disparity in domestic and international health agendas has the potential to expose vulnerable populations to forces of the international political economy by removing the state as a buffer between citizens and global forces. Yet, because these new laws and regulations take place outside of national borders and supersede national regulations, there is no clear form of governance to regulate these international interactions. Scholars have called this a “new era of public policy” that calls for novel forms of global health governance, accountability and responsibility (Kickbusch and Buse 2000). This globalization represents a period of significant change for public health, and raises questions about national and international responsibility.
The Central American Free Trade Agreement

On October 7, 2007—now a memorable date for Costa Ricans—Costa Rica very narrowly backed the Tratado de Libre Comercio (TLC), known here in the United States as the Central American Free Trade Agreement (CAFTA) by a vote of 51.6 percent. The popular referendum that took place was highly controversial. Costa Rica was the last of the participating nations to ratify and the only nation to decide via national vote.

CAFTA is a trade agreement between the United States on one side and Guatemala, Nicaragua, Honduras, El Salvador, Costa Rica, and the Dominican Republic on the other. Its aim (much like NAFTA between the United States, Canada and Mexico) is to liberalize Central American markets, creating a free trade zone. Pursuant to the terms of CAFTA, 80 percent of tariffs on U.S. exports were eliminated immediately, with remaining tariffs to be phased out over the following decade. It does not substantially reduce U.S. import duties; however, as the majority of goods produced in participating countries already enter the United States duty-free through the Caribbean Basin Initiative (CBI).

The road to the ratification of CAFTA was not a smooth one; from the start, CAFTA was an extremely contentious issue for Costa Ricans. In 2003, the Costa Rican government walked out of final discussions because, among other reasons, it could not accept the U.S. conditions regarding insurance companies. Until ratification of CAFTA, the insurance industry, along with other industries in Costa Rica, were state monopolies, and the government was rightfully fearful of powerful U.S. companies entering this market, as the financial resources of many of these companies are larger than those of the entire Costa Rican government (Homedes and Ugalde 2005).
The signing of CAFTA was the primary issue of the 2006 presidential election with Oscar Arias of *Partido Liberación Nacional* (PLN, or the National Liberation Party), who would win the election, supporting the agreement, and Ottón Solís of the *Partido Acción Ciudadana* (PAC, or the Citizens Action Party) firmly against it. Solís warned that CAFTA would cause a flood of cheap U.S. goods into the market, forcing small-scale farmers and small businesses out of the market, and would raise the cost of health care through intellectual property laws that patent drugs, and would break up national monopolies to the detriment of Costa Ricans. In 2005, he made a notable

*Figure 11: Election Day, February 2010. Costa Ricans out supporting their candidates. Yellow and red flags are for PAC (Solís); green and white is for PLN (Chinchilla). (Photos by author).*
statement, published in the *New York Times* in an article entitled “U.S. Trade Pact Divides the Central Americans,” saying, “the law of the jungle benefits the big beast. We are a very small beast” (McKinley 2005). In 2006, Solís lost narrowly to Arias, and in 2010, he ran again and lost to Arias’ PLN successor, Laura Chinchilla, popularly referred to as la marionneta (“the marionette,” or “puppet”), because of her affinity for carrying out Arias’ agenda.

There was a groundswell of popular resistance and protests against the signing of CAFTA, and even three years after the referendum, while I was in Costa Rica, strong critical reaction to its implementation remained, with prevalent accusations that the referendum was corrupt (Council on Hemispheric Affairs 2007). Polls leading up to the referendum showed that as little as three days beforehand, a majority of the population was planning to oppose CAFTA (Lydersen 2007).

On a rainy Friday night in January of 2010, I viewed a documentary called *Santo Fraude* (“Holy Fraud”) in an auditorium absolutely overflowing with enraged viewers. The film, produced by two UCR professors, detailed the coercion, lies and corruption that had taken place on the part of Arias’ government to ensure that the *Si al TLC* (“Yes to CAFTA”) camp succeeded during the referendum. Among the charges against the administration were that it bought votes from the poor for roughly forty dollars, paid for transportation to and from the polls for those who would vote “yes”, threatened the jobs of local leaders if they did not support the treaty, violated the three-day period of silence before the referendum, and used bribes and threats to ensure “yes” votes. Besides these legally questionable tactics, the “yes camp” was also accused of playing dirty in other ways by attempting to demonize their opposition through linking CAFTA opponents to
Hugo Chavez and Fidel Castro, and spending upwards of $500 million in advertising (compared to $30 million by CAFTA’s opponents).

The United States also intervened unlawfully in the vote with threats that if Costa Rica did not ratify CAFTA there would be commercial repercussions—specifically that Caribbean Basin Initiative trade preferences towards Costa Rica (wherein the U.S. government unilaterally lowers its tariffs on Costa Rican products) would not be renewed (Lydersen 2007; Third World Network 2007). In the end, despite phenomenal popular resistance within Costa Rica, “it was a Goliath with a lot of dinero beating a David” (Third World Network 2007).

The agreement took effect in January of 2009, after several attempts by CAFTA opposition to stall the process by challenging not only the outcome of the referendum, but also the constitutionality of its provisions. The effects of CAFTA were massive. Fourteen national laws needed to change in order to accommodate its terms, including, most notably, a law that opened previously public industries to privatization and international competition. Costa Rica's insurance, telecommunications, electricity distribution, petroleum distribution, potable water, sewage, and railroad transportation industries—all of which were state monopolies—opened to market competition. In the health care arena, this meant the opening of the national health insurance scheme (Instituto Nacional de Seguros, or INS) to competition from international private insurance companies. Costa Rica is unaccustomed to private insurance schemes, and national companies will likely have a hard time competing with international insurers. The terms also mean adhering to intellectual property rights provisions under TRIPS, which interferes with the ability of Central American drug industries to produce and sell affordable generic drugs. Though
the implementation of CAFTA terms has been a slow process in Costa Rica (and Costa Rica falls under the TRIPS exception until 2016) this may impact the ability of the Caja to use generic medicines in the future.

Following on the heels of CAFTA, in April 2010, Costa Rica signed free trade agreements with China and Singapore, and, in January 2011, a regional Central American–European Union (EU) trade agreement came into effect. Additionally, Costa Rica is in discussions to join the Asia–Pacific Economic Cooperation (APEC) forum and the Organization of the Petroleum Exporting Countries (OPEC) (Bureau of Western Hemisphere Affairs 2011).
Figure 12: Resistance to CAFTA/TLC. Clockwise from top left: 1) March against CAFTA, October 23, 2006; 2) Oscar Arias: “From Nobel Prize to dictator of democracy;” 3) Newspaper article: “CAFTA to favor the United States;” 4) Graffiti: “No to CAFTA;” 5) Graffiti: “God is neoliberal;” 6) Protest sign: “the principle of solidarity of the state institutions that serve the people (majority) is in great danger of disappearing if CAFTA is approved.” Sources: Author photos; Costa Rica dice: NO al TLC (Arsonheart 2006).
Global Impacts of Neoliberalism

Proponents of free trade agreements argue that they will produce jobs and stimulate the economy through new modes of international exchange of goods and services. Opponents contend that it is not further economic growth that is needed, but rather more equal distribution of wealth, and that free trade agreements only contribute further to these disparities. Critical literature on the impacts of free trade and global trade agreements have shown compelling evidence of the detrimental effects of trade liberalization and privatization of public services, finding that inequality measures worsened, and—five years after the implementation of SAPs—these measures had not yet recovered to pre-SAP rates (Labonte 2004). Furthermore, the nations that were held up as examples of the positive effects of liberalization on poverty reduction, such as India, China and Vietnam, have seen sharp increases in income inequalities along with their growing GDPs (Labonte 2004).

Latin America remains the most unequal region in the world (Morley 2001)—over the past two decades, poverty levels have risen, and an estimated 130 million Latin Americans (of a total regional population of 450 million) have little, if any, access to formal health care services (Muntaner, et al. 2006). Similar to Latin American post-reform patterns, the concentration of wealth in Costa Rica has shifted toward the upper class (Morley 2001). Between 1988 and 2005, the income of the poorest 20 percent of the population fell 13.9 percent, and that of the top 20 percent increased 67.9 percent (NotiCen 2007), while the Gini Index rose from 34.48 in 1986 to 50.31 in 2010 (World Bank 2012).

These accounts of structural adjustment and global free trade impacts call into question the “conventional wisdom” of neoliberalism that postulates a number of
assumptions about economic growth and its translation into quality of life (Scott 1998). The literature on neoliberal reforms and liberalization of trade tends to reflect just the opposite—that these reforms have meant that a small proportion of the wealthy are getting wealthier and a large percentage of poor are getting poorer. This has been the case in Costa Rica, and the problem, as many in see it, is not that the country is poor, but that accumulating wealth is not reaching the poor.

Neoliberal reforms aimed at deregulation, privatization and withdrawal of the state, have been almost universal since the 1970s, even among welfare states, though some reforms have been more coercive than by choice (Harvey 2005). The past decades have witnessed a growing role by the private sector in the payment and delivery of health care, as many states have privatized, or partially privatized their social security systems in an effort to reduce public sector spending. Yet to date, the evidence on the efficacy of privatization in improving health outcomes while reducing costs remains unconvincing.

Within the social sciences, a large body of critical literature has pointed to the negative impacts of neoliberal health policy reforms aimed at dismantling welfare states in Latin America. These neoliberal policies have been shown to exacerbate existing social and economic inequalities, increase poverty, and encourage a transfer of resources from the majority to wealthy national and international owners of capital, (e.g., Armada and Muntaneer 2004; Farmer and Castro 2004; Homedes and Ugalde 2005; Horton, et al. 2012; Navarro 1998; Turshen 1999). This literature documents not only the impacts of privatization and the neoliberal restructuring of the state, but also the unintended consequences on safety net institutions and on vulnerable populations.

Particularly in Latin America, where social welfare states were so strong, neoliberal
policies raise questions about state sovereignty and the appropriate role of the state in health care provision. Whereas the role and responsibility of the state under social medicine is to protect and promote social and economic well-being of the population, the role of the state under neoliberalism is to create markets where there are none, preserve an institutional framework appropriate to market practices, and to guarantee the proper functioning of markets. Beyond that, state intervention is minimal (Harvey 2005).

Though we are now aware what the economic consequences have been of neoliberal reforms on the ground, what remains less clear are the impacts at an ideological level. More than just a questionable economic decision, the signing of CAFTA was an ideological blow for Costa Ricans who were so proud of their social developments and the fact that they had achieved them in their own way. As Laura Carlsen, the director of the Americas Policy Program said after the referendum,

"It wasn't just a vote on CAFTA, but a clash between two different models of development... this will come up not only in implementing legislation but in elections and all types of situations where you find a choice or potential choice between those two models of more state involvement and distribution of wealth, versus leaving things to the international market (In Lydersen 2007)."

Unlike SAPs, wherein the Costa Rican government had little choice in implementing neoliberal reforms (and even then, resisted implementation), with CAFTA, there was a choice, and the government intentionally chose a path towards globalization. In the eyes of the public and CAFTA critics, this choice meant “a renunciation of the national project” (Vargas Solís 2004).

**Individual Impacts of Neoliberalism**

Neoliberalism represents a more ubiquitous global shift that is occurring as it has transformed from a novel economic configuration to a dominant hegemonic discourse
and ethic in itself, capable of guiding human action (Harvey 2005). The underlying assumption, that maximizing the reach of the market maximizes social good, has become pervasive. Even as delivering health care through for-profit health insurance companies has so clearly failed to improve health outcomes or reduce costs, there is still incredible ideological investment in neoliberalism (Horton, et al. 2012), which has spilled over into personal values. Neoliberal values of freedom, individual choice, competition and individual responsibility (Harvey 2005) have become tied to what it means to be a responsible citizen, and this rhetoric has become commonplace in discussions of health care provision and reform.

Neoliberalism has, in short, become hegemonic as a mode of discourse. It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in, and understand the world” (Harvey 2005).

From the clash of ideologies that is taking place in Costa Rica—the social vision of health as a right and the neoliberal vision of health as a commodity—has emerged a new class of neoliberal actors who are able to navigate both worlds. Those who work within medical tourism have become savvy entrepreneurs, attracting medical tourists with their “global” medical expertise and cosmopolitanism, as well as the Costa Rican caregiving values, warmth and hospitality that medical tourists desire.

Costa Rican physicians, previously considered servants of the state, now exercise and defend their freedom of choice to work in the private sector where they can earn a higher salary and enjoy a calmer work environment. Medical residents, trained by the public system, exercise the same choice to leave the Caja, or to practice medicine in a location of their choosing. These individual freedoms are overtaking the sense of social responsibility that once guided the career of the physician. Their justifications fit within a
neoliberal framework that emphasizes individual freedoms, and uncritically severs them from their consequences. I asked one physician about the growing number of medical residents who finish their training in the Caja and then leave for the private sector, and she responded quickly, “Yes, of course they do. It is their choice. Why shouldn’t they?” (23). The separation of public and private spheres, as mentioned in Chapter Three, is internalized by physicians, allowing them to disconnect their treatment of medical tourists from its effects on the public system. When they do acknowledge the intersecting nature of the spheres, it is not their own personal actions that were to blame, but rather the actions of others. A plastic surgeon who left the Caja for the private sector, where he works almost exclusively with medical tourists, told me:

The anesthesiologists, most of them, they left the Caja. That was a mess. As I am telling you, I don’t feel guilty because I perform cosmetic surgery, that’s why I don’t feel guilty at all. But in other areas, it can be very messy. Medical tourism can be good and bad. It will happen with other specialties too. It hasn’t happened yet because there are not enough patients from outside, but if this is going to be a major thing, it is going to be a mess. It is going to have a huge impact on the Caja. Huge. (21)

This attitude of moral and political passivity (Gramsci 1971) that goes along with unconscious adherence to neoliberalism, serves to perpetuate its expansion by reducing these decisions to matters of individual choice and ignoring the connection to the broader forces that shape these choices.

Aside from neoliberal physicians who exercise their choice, there are also neoliberal patients developing in Costa Rica, who have new expectations of speed, quality and choice within health care, and newly engrained notions of personal responsibility to take control over their own health. In the face of changing global demographic conditions—namely an aging population with more chronic disease—
neoliberal reforms have emphasized this individual responsibility as part of what it means to be a responsible citizen (Horton, et al. 2012). In a discussion of Foucault’s lecture on governmentality and neoliberalism, Lemke says,

The strategy of rendering individual subjects ‘responsible’ (and also collectives, such as families, associations, etc.) entails shifting the responsibility for social risks such as illness, unemployment, poverty, etc., and for life in society into the domain for which the individual is responsible and transforming it into a problem of ‘self-care’. The key feature of the neoliberal rationality is the congruence it endeavors to achieve between a responsible and moral individual and an economic–rational actor. (2001)

This is part of what has been called the “great risk shift,” (Hacker 2006) wherein individual citizens and families begin to shoulder the economic burden of their own health care, rather than larger structures like insurance companies, employers, the corporate sector, or the state. In Costa Rica, citizens who were previously under the care of the state must now take it upon themselves to provide care for their families when the Caja cannot meet their expectations of timeliness or quality. A rising number of patients now seek care in the private sector as a pragmatic strategy for savvy patients who can successfully weave between the public and private spheres to meet their needs. Under neoliberalism, while the responsibility for health care falls away from corporate and private entities, families are often left to bear the burden of additional costs. Costa Rican families increasingly incur higher costs for care when they use the private sector as a health care strategy, because they are already paying for their care within the Caja.

Neoliberalism encourages individuals to give their lives an entrepreneurial form (Harvey 2005). The new neoliberal patient is armed with information, demanding choice, and encouraging competition between providers for their business. A private physician said that medical tourism “is a matter of globalization. People shop around now for things
like this. They are informed and they will go wherever they need to, to get done what
they want done” (25). Another said “it is just doctor shopping. The patient goes shopping.
Doctor shopping from shop to shop—who is cheaper? Which one do you like best?” (30).

This issue of choice is a controversial one in Costa Rica, because, while choice is
a central tenet of neoliberalism (therefore medical tourism and private medicine), patients
within the public sector are typically not able to choose their physician or their
medicines. But exposure to private medicine has created new expectations of individual
choice, and this is becoming a more contentious issue, and many believe that Caja
patients should be able to choose both. Because of increasing advertising by
pharmaceutical companies and higher private sector usage, patients are now becoming
aware that there are medications in the private sector that they cannot get within the Caja.
A public sector official explained,

Some physicians are using private medications on their patients. And
those patients receive information from other patients and the internet, so
when they come back here to the Caja, we are facing a big issue because
we are talking about budgets that Caja just doesn’t have [for those
medicines]…Here in the waiting room, when they are admitted, they share
information with the patients and their families, and some Costa Rican
patients are becoming more demanding. (20)

An infectious disease specialist told me that when he sees patients at the Caja and wants
to give the patient medicines that are not available within the Caja, he obtains the
medicines from his private practice and leaves samples for the patient to pick up.

There are current cases in the Costa Rican Constitutional Court, Sala IV, wherein
patients are demanding access to expensive drugs within the Caja. The court is currently
considering whether or not to declare the denial of name brand drugs by the Caja
unconstitutional, as against the right to life. If this occurs, it will have a dramatic impact on the Caja and their ability to provide medicines within their already strained budget.

Other authors (e.g., Biehl 2006; Biehl 2007; Goldstein 2007; Petryna 2009; Petryna 2011) have documented that the pharmaceutical industry itself is often behind the movement to sue the state for access to name brand drugs. Although lawsuits have secured access to these expensive medicines elsewhere in Latin America, this “judicialization of the right to health” (Petryna 2011) creates enormous administrative and fiscal burdens on public systems, and contributes to worsening inequities. This co-opting of the “right to health” discourse within a neoliberal expansion of pharmaceuticals under free trade, is particularly interesting in the context of Latin America, where social medicine and solidarity have been so important.

Patients within the private sector are viewed by physicians as demanding, entitled or “special” as compared to patients in the Caja. One physician said,

Well, the thing with private patients, they are, uh, special [laughs]. You have to answer the phone at any moment, for just anything. Sometimes, it’s like 2am in the morning and they call to say ‘my hair hurts doctor, what can I take?’ And you cannot just say ‘are you crazy?!’ You have to say ‘don’t worry madame, everything is going to be just fine. You know, things like that... it’s because of the price. (38)

Contrast this with a Caja patient, as described by a public sector nurse, who is “silent, tolerant, he puts down his head, he plays dumb with the things that are done to him or with the things he sees... The Caja client also pays, but we see it as if they don’t pay” (44). Within the private sector, users are often called “clients” or “customers,” whereas in the public sector, they are referred to as patients. Private sector patients are seen as active agents, taking control of their
health, while public patients are seen as passive, inertly waiting in line for their care, and relegating their health care needs to the inefficient and prescriptive state.

**The Love—Hate Relationship with the State**

The neoliberal economic principles under which privatization and medical tourism are occurring in Costa Rica affect the way that people think about health care. But the ways that Costa Ricans have been integrating these principles into their understandings of health care is, in many ways, aligned with their history of social medicine. The resistance to neoliberal reforms and privatization, in particular, reveal the degree to which the welfare state in Costa Rica is fundamental to national identity and health citizenship. The co-opting of a “right to health” discourse in accessing private facilities, and in demanding certain medicines and physicians is also in line with the foundational belief that all citizens should have access to health care. Even the justification for medical tourism, which will be discussed in more detail in the two chapters that follow, is built atop the national belief in the right to health for all.

The successful development of the social security system in Costa Rica was effective, in that it made people believe that health care is a right. The resistance to neoliberal reforms has demonstrated the value that Costa Ricans have placed in state-sponsored health care. The current disenchantment with the Caja is not a critique of social medicine, but rather public dissatisfaction with the chipping away of the system’s social foundations. As Seligson (2002) says, “Ironic as it may seem, the success of state-run enterprises has resulted in a negative evaluation of the Costa Rican state because of its efforts to scale back or dissolve these enterprises.” The state is withdrawing where Costa Ricans believe it should remain strong. Costa Ricans seem to be involved in a
“love—hate relationship” with the state. Though the neoliberal blueprint is the same, the way that neoliberal discourse takes shape in Costa Rica is novel in that it is undermined by a strong belief in social medicine and solidarity.
CHAPTER 6: LOCAL EXPERIENCES OF MEDICAL TOURISM

Medical tourism was declared an “activity of national interest” by the Costa Rican government in 2008 (under the Arias administration) because of its potential to bring revenue into the health sector and bolster auxiliary industries like tourism, transportation, hotels and recovery homes. The Ministry of Tourism (ICT) estimates that each medical tourist stays in the country 11 days and spends between $6,500 and $7,000, more than four times what a regular tourist would spend (Brenes 2011). This declaration has resulted in government promotion of medical tourism locally and abroad, emphasis on international accreditation for private hospitals and clinics, support for international agreements with insurance companies and employers, and foreign and national investment in the medical infrastructure. It also means that the government responds more quickly in matters where medical tourism or foreign investment in health facilities are concerned—as in giving visas or residency to foreigners, fast-tracking permits for health facilities, and “cutting through some red tape,” as one participant told me. “It means that there is a special commitment of all public institutions to work with the private sector in this field” (16).

National Actors and the Health Care Cluster

Costa Rica formed a “health care cluster” to promote medical tourism, as prescribed by the Medical Tourism Association (see Chapter One), to join both public and private sector entities with a vested interest in the industry. There is also a national medical tourism promotion agency, PROMED (the Council for International Promotion of Costa Rican Medicine), established in 2008 to represent the common interests of the stakeholders in the medical tourism industry, communicate with the public sector, and
ensure sustainable growth of the industry. The health care cluster, as laid out by the ex-
Minister of Competitiveness and Regulatory Improvement, Jorge Woodbridge (who was
instrumental in the declaration of medical tourism as an activity of national interest)
includes a significant role for government entities and public universities in support of
the medical tourism industry.

According to Bill Cook, MTA member, and operations manager for the
international patient department of Clínica Bíblica, “the government’s role is that of a
referee and supporter: guaranteeing that quality standards are maintained, defining the
rules of the game, and eliminating potential bottlenecks with regard to human resources,
technology, infrastructure, and immigration that could hinder development” (Cook 2008).
Specifically, the cluster calls for “an aggressive government-sponsored marketing
campaign” to be launched, as well as attention to the human resource capacity that is
needed to expand the industry.

The Caja and public universities are tasked with the formation of human resources
to support the industry, while the government’s role is to “prepare the country” for
medical tourism. This includes instituting quality measures for private facilities, working
with the nation’s universities to encourage them to focus on specialties that are in demand
by medical tourists, preparing more bilingual nurses and doctors, and encouraging post-
graduate training in the United States or in Europe “to provide them [health care workers]
with the characteristics and training that the international market demands” (18). One
government official said, “Without the triangle of the public sector – private sector – and
universities, the medical tourism master plan would not work” (16). The following two
figures illustrate the way in which the health care cluster supports private clinics, and the expected roles of the government within the industry.

*Figure 13: The health care cluster, which supports and promotes the Costa Rican medical tourism industry (Ministerio de Producción 2010).*
Figure 14: The role of the government in supporting the medical tourism industry. (Adapted from Ministerio de Producción 2010)

Most interview participants were pleased that the government was at least attempting to organize and promote the industry and the image of Costa Rica. Beyond this general role, however, they felt that the government should have very little involvement in the medical tourism industry. This was typically related to the public–private divide, as an extension of the neoliberal belief that the state should not get involved in private industry. Not surprisingly, this view was expressed more often by those who profited significantly from medical tourism. But others had a more “social” reason—that the government should not be involved because it is a conflict of interest of sorts to spend time and resources promoting a private industry instead of caring for the Costa Rican population, which is the state’s responsibility.

Though it was typically denied that the government had much involvement in medical tourism, the Costa Rican government sponsors the World Medical Tourism and
Global Health Congress (WMTGHC – the trade conference of the MTA), and promotes the industry and the image of Costa Rica through other events, and magazines. Medical tourism is also advertised through the Ministry of Tourism (ICT), whose new slogan, “Here we cure all,” attempts to highlight Costa Rica’s reputation as a medical tourism destination. The most costly form of subsidy that the government and the Caja provide, however, is the public education and training of the health care workers that support the medical tourism industry. Despite these contributions to the growth of the industry, the public sector and the Caja reap little benefit from it.

**Emerging Industry Actors as Gatekeepers**

Private hospital physicians told me that medical tourism has been happening in a more informal sense for decades. One example of these unofficial networks came from a plastic surgeon, who took out a small advertisement in the *Tico Times* (an English language newspaper in Costa Rica) and had a woman from California respond to the ad and come to him for a facelift 15 years ago. She was so pleased with the results that she has continued to bring patients from her large religious congregation down to Costa Rica a few times a year for procedures with him ever since (and has received several more procedures of her own). Another plastic surgeon similarly built his practice from word of mouth, and expressed annoyance with the development of the industry, saying,

This is not a new experience. The media are trying to make it seem like it is, like it is this “boom,” but before the internet was an active tool for us to find these patients, maybe ten plastic surgeons from here, including me, and some physicians in other areas worked in medical tourism. Now this industry—they are trying to make it seem like they discovered warm water… there are a lot of people trying to do business from this, but this is something I’ve been doing for years...now I have people constantly coming to me telling me they want to work with me, as an intermediary…everyone wants to make money off the work of others.
They try to invent things that already work and they just insert themselves in the middle. (15)

The national agenda to promote the medical tourism industry has meant that more actors are becoming involved in medical tourism. In addition to international associations, facilitator companies, insurance companies and other global actors discussed in Chapter One, there are several national stakeholders emerging in Costa Rica.

PROMED works with the “big three” hospitals, smaller private clinics, and providers in the transportation, accommodation, aftercare, and tourism industries to ensure that regulatory standards are met, and to comprise a “unified front” for promoting the industry. The group recently developed a PROMED seal of approval to signal quality of the providers whom they work with. Providers in Costa Rica pay PROMED to go through this process, just as they pay fees to become accredited health care facilities, to be certified by the MTA, or to be part of a physician group within the medical travel industry. On top of these certification and accreditation fees, there are also membership fees to be part of these organizations.

The Costa Rican Medical Holding Company (CRMHC) also emerged in recent years, started by a plastic surgeon who works with medical tourists. CRMHC (affiliated with PROMED) is a consortium of private physicians from the “big three” medical tourism hospitals, who also pay fees to become members of the group. The consortium then promotes medical tourism in the United States and “formalizes links” within the industry, including accommodations, transportation and tours for medical tourists.

The “big three” hospitals all have international patient coordinators or international departments within the hospital to help with the special needs of medical tourists—including coordinating their accommodations and tours and dealing with
international insurance agencies. Even though the international departments are within the hospital, they are operated as separate companies and are paid by the hospital for attracting medical tourists.

In popular perception, organizing and presenting a unified front for medical tourism is important, but most feel that these actors do very little, in practical terms, to advance the industry. Like the plastic surgeon above, many physicians involved in medical tourism see these organizations as gatekeepers, who invent functions and insert themselves into the industry, working to protect the financial interests of a small group of stakeholders who profit from medical tourism. A few questions into an interview with an orthopedic surgeon, he laughed and said,

Oh, okay, you want to know the real business? These guys [industry actors] are trying to control everything. They are like octopuses in the middle, trying to control all the business and all the money. It’s incredible, one company tries to absorb the other… accreditations, associations, facilitators, I mean, what do all these people do? I met a lady in the United States who owned some internet name that had medical tourism in the title, she had some tiny business, and someone came and bought it from her for five million dollars…he just wanted the name. It’s just big business that’s going on. And now the insurance companies are coming down from the States… and we [physicians] are the last part of the chain. There is the patient at one end, and we doctors at this end, and then all of these companies in between. That is going to increase prices and decrease the quality of attention. (9)

One young physician said that she paid nearly $3,000 to join CRMHC. When asked if she had received any foreign patients through the group, she said with a roll of her eyes, “Zero. Absolutely nothing” (38). Another private sector physician remarked that, “even though PROMED is a non-profit, they can say, ‘I’m in the group and if you want to come in then I want something from you.’ They can move their chips so you cannot be in the group. It is very political” (10).
Creating Special Spaces for Medical Tourists

Despite a general belief that the government should have limited involvement in the industry, one physician, who ran his own physician group, told me that he hopes that the government takes their commitment to promoting medical tourism even further—by creating special considerations for traveling medical tourists—like skipping to the front of customs lines and priority boarding on airplanes to return home. “We need special spaces for them,” (35) he told me.

Indeed, medical tourists do enjoy special spaces in Costa Rica. The “big three” private hospitals offer sleek, modern accommodations for medical tourists, and several amenities within and outside of the hospitals.

*Hospital Hotel La Católica,* which used to be run by nuns, was purchased by a private investment group of Oscar Arias, which renovated the former convent into a colonial-style hotel for medical tourists. Of this purchase, a UCR professor said, “it is not in vain that one begins to associate free trade, the opening of these markets, and Arias declaring medical tourism an activity of national interest…and then you can go around like that and put together the pieces of the puzzle” (7).

Adjoining the hospital part of *La Católica,* a cobblestone pathway, lined with candles, opens to a large courtyard, lined with private hotel rooms. A marble fountain is featured prominently in the center of the yard. Patients staying at the hotel can choose to take their lunch from the on-site restaurant to the patio if they are feeling up for it.

Just off the courtyard are a Pilates studio, a nutrition center, and a trio of hyperbaric chambers—the largest of which resembles the fuselage of an airplane and can seat up to eight patients at a time. The chambers, which allow patients to breathe pure
oxygen to assist with recovery, each face a television, and an attendant monitors the patients while they use the chambers.

*CIMA*, located in a suburb of San José that is sometimes called “Little America” because it is home to so many expatriates, is sandwiched between two American-style hotels—a Mariott on one end, and a Holiday Inn on the other, “strategically located for increasing patient populations” (40). Both are brand new. Just outside the hospital, there is a park for patients to walk, an IMAX Theater, and *Avenida Escazu*, a row of high-end retail stores and restaurants. The expansive and polished lobby of the hospital houses an upscale restaurant, an international insurance claims office, and a United States Veterans Affairs office right in the lobby. Ophelia, CIMA’s international patient coordinator, takes care of all arrangements for international patients—including setting up tours to see Costa Rican volcanoes, beaches, or other attractions, in addition, of course, to coordinating the patient’s medical needs.

Another shining example of these special spaces is *Clínica Bíblica*, the oldest and largest private hospital in Costa Rica, founded by evangelical missionaries in 1921, and purchased by a group of entrepreneurs (ASEMECO) in 1968. It has been progressively expanding since it was purchased, and most recently added the modern “Omega Tower” in 2003.

Furnishings in *La Bíblica* are minimal and contemporary, though both doctors and nurses dress in traditional garb (doctors in monogrammed white coats, and nurses in crisp blue and white uniforms with a traditional nurse’s cap). Inside the hospital, patients can find a food court, a bank, a salon and barbershop, coffee shop, internet café, and pharmacy. There are raised covered walkways between the hospital’s buildings, making
it almost unnecessary to leave the hospital. A piano player plays in the lobby during the busier times. There is an international office and patient coordinator here as well, who take care of all aspects of a patient’s visit, including transportation to and from the airport and hospital.

The patient rooms in each of these hospitals are private and well appointed, with ample furniture for patients to unpack their belongings, a place for family to sit or sleep, flat screen televisions, and personal bathrooms. There are also suites available, which typically include a second sitting and sleeping room for patients and their guests. Nurses and physicians are friendly, nicely uniformed, and speak English. Calming music plays in the halls, which are quiet, and in some cases, seem nearly empty. Waiting areas have televisions, magazines, leather sofas and armchairs, and local artwork adorns the walls. These private medical spaces are a very sharp contrast to the crowded, chaotic scenes that I witnessed in Caja hospitals and clinics.

Post-surgery, medical tourists can choose to recover in nearby hotels or recovery homes that are designed with rehabilitation in mind, which typically include all meals and amenities so that guests rarely, if ever, have to leave the premises. Attendants at these facilities cook and clean, run errands, take patients to and from follow-up appointments, change bandages, and sometimes act as therapists, helping patients to heal both mentally and physically. In one facility that I visited, a plastic surgeon kept an exam room at the recovery home so that he could stop there on his way home from the hospital to check up on several patients at once. There are also aftercare companies, like a company called Homewatch, which is affiliated with the MTA, which will care for the patient once their
Figure 15: The special spaces of medical tourists. Clockwise from top: CIMA San Jose building; the waiting area of a private plastic surgeons office; entrance to Hospital Hotel La Católica; the Marriott Hotel at CIMA Hospital, with a park in foreground; lighted walkway to the Omega Tower at Clínica Bíblica (Horizon Pacific 2012); the courtyard of La Católica. (All photo but one is by author).
surgery is complete. They offer similar amenities to the recovery homes should a patient opt to stay in a hotel instead.

These are the “special spaces” of medical tourists—gleaming and modern—with every amenity, carefully purified of Third World conditions that are incompatible within the idyllic Costa Rican image that the industry promotes, and that medical tourists expect. These spaces are global spaces, and medical tourists are protected from the local surroundings. Around them sit the dirty, crowded, pot-holed streets of San José, and the barred windows of local shops and homes. This is a quite literal contrast in the case of Clínica Bíblica, which sits directly in downtown San José. Violent crime and poverty are on the rise here, as in the rest of Costa Rica, and trash disposal and environmental degradation have become widespread problems, despite the nation’s green image. These negative developments are cause for concern among locals, who are worry that Costa Rica exceptionalism may be eroding, and the nation is becoming more and more like its Central American neighbors (e.g, Ordoñez 2007; Seligson 2002)

The State of the Medical Tourism Industry in Costa Rica

Medical tourists come to Costa Rica primarily from the United States, which is viewed as the primary target for the industry. Those seeking care in Costa Rica are, for the most part, uninsured, underinsured, or seeking a procedure that insurance will not cover. Although CAFTA opened the insurance market to international competition, and a few insurance companies have begun to cover medical tourism options, the bulk of medical tourists pay out of pocket. This is likely because elective surgeries, which insurance plans will not cover, remain the most popular procedures. American medical tourists tend to choose Costa Rica because of its geographic proximity, successful health
care system, national image of being peaceful, happy, and green, and because its natural beauty makes it a nice place to recuperate. The “pura vida”\textsuperscript{25} attitude of Costa Ricans is also a draw for Americans who desire to escape the injustices of U.S. health care to the “competence, kindness, and leisurely pace of Costa Rican medicine” (Ackerman 2009).

Like the global medical tourism industry, inconsistent definitions and methods for collecting and reporting industry data make it extremely difficult to provide an accurate estimate of the number of medical tourists traveling to Costa Rica for health care. National estimates vary wildly, from just over 2,200 patients per year, to as many as 100,000 (e.g., Aérea de Turismo Receptor 2009; Arce 2011b; Arguedas 2009; Brenes 2011; Ministerio de Producción 2010; PROMED 2010). The reality is probably somewhere in-between, and the most often cited figures are in the area of 30,000 medical tourists annually. When advertising the industry, over-reporting numbers of visiting medical tourists is a very common practice, as is the underreporting of patient numbers among private facilities to avoid paying taxes. In her study of plastic surgery tourism in Costa Rica, Ackerman (2010) was told that plastic surgeons typically pay income tax on only ten percent of their private practice earnings. This underreporting calls into question the neoliberal logic of industry benefits that proposes that the industry benefits the Costa Rican government, and the Caja, through an increased GDP that “trickles down.”

In Latin America in general, and Costa Rica in particular, medical tourism centers on elective surgeries, primarily plastic surgery and cosmetic dentistry. However, these procedures tend to be the least profitable for hospitals because they are often performed

\textsuperscript{25} \textit{Pura vida} is a universally known Costa Rican expression that is used to describe the laid back Costa Rican attitude. It literally translates to “pure life” or “plenty of life,” but is used commonly as a greeting, or in response to the question “how are you?”
on an outpatient basis; the physician typically provides necessary equipment and supplies, and the patient recuperates in a recovery home instead of at the hospital. Consequently, the industry is attempting to expand the market for orthopedic procedures, bariatric and weight loss surgeries, liberation therapy for multiple sclerosis, and corporate wellness exams, and other procedures considered to be more necessary, and more profitable.

Until June of 2010, Costa Rica was home to a stem cell clinic. The Institute for Cellular Medicine (ICM), owned by an Arizona entrepreneur, operated out of CIMA Hospital for four years before it was shut down by the Ministry of Health. The reason cited for its closing was a lack of evidence that stem cell treatments were effective, with the Minister of Health stating, “This isn’t allowed in any serious country in the world” (Ávila 2010). The medical tourism industry in Costa Rica wants very much to be taken seriously, and to protect its reputation amongst Americans in particular. In closing the ICM, the Ministry of Health showed its deference to U.S. biomedical values, signaling again that the industry is on par with American quality standards. While it was open, about 400 patients were treated at ICM, with treatments ranging from $5,000 to $30,000. After its closing, the patient load was moved to another facility in Panama (Carroll 2010).

**Local Hopes for Medical Tourism**

Since its declaration as an activity of national interest, the country has been preparing for a large number of medical tourists, and many have very high hopes for the future of the industry, though these have not yet been realized. During tours of private hospitals CIMA and Clínica Bíblica, I was told that the hospitals would like to have an entire floor dedicated to medical tourism, staffed with English-speaking physicians,
nurses and administrators. The international patient coordinator at CIMA showed me an empty floor in one of the complex’s recently constructed buildings, which faced the Holiday Inn that was under construction, and said “we are waiting for more medical tourists to come fill it.”

An orthopedic surgeon at one of the private hospitals told me that the industry is planning specifically for bariatric surgery, orthopedic surgery, and dental procedures. “Those are going to be the ones,” he told me, “and it is incredible how they are preparing.” He told Karina and me that he had received two emails and two interview requests the week that I spoke with him from physicians who were interested in investing in these fields. “They don’t want to open an office here,” he said, “they want to open hospitals here.” When asked where they were from, he responded “The States! Of course.” I asked him if he thought that the Costa Rican government would be concerned about such expansion, and he answered “Maybe 20 years afterwards, but not right now. Because they’re going to make money, the facilities will pay taxes—everyone is going to be happy about it… at the beginning” (9).

In making his case for medical tourism, Minister Woodbridge (n.d.) summarized the anticipated benefits for Costa Rica as follows:

- Increased flows of direct foreign investment and export of services;
- More and better opportunities for professionals in medicine;
- Highly competitive health care prices for Costa Ricans;
- Higher standards and continuous improvement of hospital standards (not only for foreign patients but also national patients);
- Higher profits for the healthcare industry and its value chain (hotels, restaurants, travel agencies, airlines, pharmaceutical, equipment, doctors, etc.);
- Creation of a Corporate Social Responsibility Fund financed by private institutions to develop social health projects.
These arguments in support of medical tourism, which are quite similar to standard endorsements provided by proponents of the global industry, are mainly neoliberal in nature and operate on the assumption that increased revenue and competition will improve the conditions of the country and complement public health efforts. The extent to which this is actually happening is addressed later in the chapter.

Most stakeholders I interviewed, especially in the private sector, had high hopes for the growth of medical tourism and the opportunities that it presents for the country, sharing the Minister Woodbridge’s optimism about the potential for the industry to improve standards of living. One plastic surgeon, with substantial stakes in the industry, described medical tourism as a valuable tool for helping Costa Rica become a developed country. He said,

I really like to dream, because I am an example of that dream. I came from a lower-middle class family, went to public high school and public university—and nowadays I am on the top of medical tourism in Costa Rica, so Costa Rica is a country of opportunities... This is Costa Rica’s plan for the future. We really believe that medical tourism, because of the level of income for the country, is the main tool to become a developed country, which we have been waiting for for many years.

It will provide not only money to the government, but also hope for the school system, for the students, because if you have a rich country and higher income, they will have more opportunities. And obviously we don’t want everybody to become a doctor or a nurse, but medical tourism and globalized medicine involves everything...hotels, recovery facilities, pharmaceuticals, transportation, food, hospitals, infrastructure, entertainment, safety and security, communications; it involves everything! So the globalized medicine project, as a country, means that there will be opportunities for every single sector in the country.

Plus it is sustainable, ecologically friendly, and socially responsible. The patient not only receives low cost, high quality care, but warm treatment by staff and the knowledge that they are supporting a country that believes in peace, health and education. (35)
In a subsequent discussion, this participant even stated that he thought medical tourism would reduce violence, prostitution and sex tourism in Costa Rica, by giving the tourism industry something “prestigious and legitimate” to focus on.

Though not all stakeholders interviewed had such lofty goals for medical tourism, most did see at least some potential advantages of promoting the industry at a national level, the most oft-cited of which was increased national revenue. Current national figures projects that medical tourism brought $288 million to Costa Rica in 2010 (Brenes 2011), though due the data collection issues mentioned above, this is difficult to confirm. Even though increased revenue was recognized as a principal positive effect of medical tourism, none of the participants interviewed offered evidence of any direct benefit to the Caja or public system. The logic is merely that a rising tide will lift all boats.

Local Anxieties about Medical Tourism

Competition

*International Competition*

Opportunistic moves, like the relocation of the stem cell clinic from Costa Rica to Panama, are not uncommon within the industry, and many with investments in medical tourism in Costa Rica worry about being undercut by neighboring nations and losing the industry altogether. As with other forms of outsourcing, this has created an atmosphere of competition amongst Latin American countries, which know that they cannot compete with the much lower costs of health care in Asia, but, because of geographic proximity, they can compete for Americans against other Latin American nations. Competition is a key principle of neoliberal discourse, which assumes it will reduce costs and increase efficiency. If one destination country will not undertake a procedure or if prices are too
high, the next one in line will. Among those with investments in medical tourism, there is a prevalent fear about being “outcompeted” and losing business to a neighboring country if the government does not act quickly to promote the industry and decrease regulatory barriers. One medical tourism facilitator urged,

They [the government] must see the opportunity right now. Because Panama is growing, Colombia is growing—Colombia has a cleaner image year after year, and Panama has enough money and infrastructure, but they have a lack of JCI hospitals and physicians, but five years from now… the situation will be absolutely different. (35)

Another physician added, “Look how dangerous the future could be…we don’t know how much longer Cuba will remain Communist. If Cuba opens up, everything goes to hell. Even Nicaragua, what if things come back to life there, and they promote medical tourism? My God, they will beat us… definitely” (42). Others spoke of the fickle nature of the tourism industry and worried that, after all of this investment in medical tourism, the “boom” might be over in a few years. A Caja physician asked, “Will our country be the Eden, or will it be somewhere else? There are so many tourist spots that were popular ten years ago and are abandoned now. It is unpredictable” (23).

Fear of losing business to neighboring countries has resulted in various changes to medical tourism practices in Costa Rica. Physicians sometimes feel pressured—by facilitator companies, physician groups, or hospitals—to reduce their prices to remain competitive. While some see price reduction as an effective strategy for promoting medical tourism “in bulk” to receive a larger volume of patients, others feel taken advantage of by continually being pushed to reduce prices. One private sector surgeon said:

I have been working with facilitators, and they are always saying, ‘we will bring you patients,’ but the problem is the prices—I think they are trying
to prostitute our practice. So, for example, if I do a surgery, the hospital reduces the prices a little bit, but mostly it is us, the physicians…why do we have to go lower and lower? I mean the only people who change their prices for this is the doctor, the surgeon. What about the others? We cannot… I mean this is the lowest we can do. I don’t know, I think its prostitution. (38)

National Competition

There is also internal competition amongst the “big three” private hospitals to attract patients. Although the industry attempts to promote the country as a whole, and present a united front in attracting medical tourists, once the tourists come, the “private sector has to compete to capture them. At that point, it is all self-interest” (5). Though all three of the hospitals are JCI accredited and attract medical tourists, on several occasions, I was told that there is inferior quality at the other private hospitals, that prices are too high, or that their practices are not transparent. Trying to undercut competing hospitals and physicians is common practice. One physician at CIMA even told me to “go and tell Clínica Bíblica to stop saying bad things about us” when I was there next (40). With the opening of two new private hospitals in San José since 2010, and more facilities scheduled to be opened in other parts of the country, the internal competition between hospitals trying to attract medical tourists is likely to heat up even more.

Individual Competition

Even within private hospitals, physicians are sometimes pitted against each other to reduce prices. The medical director of one of the “big three” hospitals told me that, when a medical tourist contacts the hospital, he chooses three physicians and asks them to give price quotes for the desired procedure, and then offers the tourist the cheapest price of the three. “And then later we explain to the other two doctors why we did not
choose them—to make the point that, if an American comes here, it is to look for the cheapest price, not to pay the same as in the United States” (12).

Though most who were involved in medical tourism told me that prices for procedures are fixed and it did not matter whether it is a Costa Rican or a medical tourist seeking the procedure, this is not always the case. To attract a larger volume of medical tourists, some physicians offer lower prices to foreigners than to Costa Ricans. Others, however, feel that medical tourists are able to pay higher prices for procedures and that they demand more attention and aftercare, so had a policy of quoting prices on a case-by-case basis, depending on circumstances, which typically results in charging higher prices for the traveling patients. Either one of these strategies—raising or lowering prices strictly for medical tourists— illustrates that medical tourists are treated differently than Costa Ricans. If prices are cut for Americans, who can afford to use private care more than Costa Ricans, this is ethically questionable. If prices are raised for medical tourists, this has the potential to drive the costs of private care up, decreasing access for locals. “They would consider it very expensive,” one government official stated. “I mean someone from the States, they might think $5,000 for a surgery is cheap, but for a Costa Rican, it is very, very expensive” (27). A retired Caja physician said this is one of his main concerns—that after focusing on medical tourism for a few years, the cost of private medicine will go up,

We might have four or five years with this “boom” of patients, and so we raise the costs of private care, and this is going to reduce access for Ticos. Because we are almost 5 million people, but not even 1 million of us can pay for private medicine. If medical tourism is a small business, I think that is better. It is better to just continue with accessible rates for medicine and live with that, rather than to try and take all the money for—what? Five years and that’s it? And after that, what? I’m really concerned about
that. Most of my colleagues [physicians] they want to take *everything* and take it *now*. But this is medicine. This should not be like that. (32)

**Capacity**

An international medical tourism executive whom I spoke with shared in the hopes for industry growth, but at the same time had concerns that it might be a “field of dreams” scenario, asking, “What if we build it and they [the medical tourists] don’t come?” This is of particular concern among stakeholders who are building and investing so much in the industry during the current economic crisis. One physician told me that, before the crisis, he was “saturated, doing all of the surgeries that I wanted to do, but now it has gone down, down, down” (19). A hospital administrator said that they had hoped to attract around 80 patients per month, and are currently getting only about 30 medical tourists at most.

The fact that there are 47 million uninsured Americans came up numerous times in interviews as an indication that medical tourism would grow in Costa Rica. One private sector physician stated hopefully:

> I mean, there are plenty of patients in North America for all of us. We don’t have space available for all the people that need help in the States…we are still not even approaching 0.001% of those patients that need medical services in the U.S. (9)

His comment not only illustrates Costa Ricans’ expectations for the industry, but also touches on a question raised by other participants; whether Costa Rica has the capacity to accommodate a medical tourism “boom.” Costa Rica is a country of 4.5 million people marketing to a potential population of 47 million. At the time that this research was conducted, there were only three JCI accredited private hospitals in Costa Rica working with medical tourists. Although more facilities that target medical tourists
are in the works, some participants wondered if Costa Rica could support a sizable surge of foreign patients. Just as there is anxiety about what will happen if “they don’t come,” there is concern about what will happen if they do come:

If you bring me one patient for a gallbladder removal, that is fine,” a private sector physician said, “but if you give me 100, and they all come in the same month, you’d flood me. That would shut down my operation. I couldn’t see anyone else but that. It is very easy to overwhelm these structures. They are not designed for volume. (34)

Especially with the entry of private insurance companies, which may incite a higher volume of patients traveling to Costa Rica for procedures covered on their insurance plans, many worry about whether Costa Rica has enough facilities, infrastructure, and human resources to accommodate substantially more medical tourists. Even if it does, will this accommodation come at the expense of Costa Rican residents?

**Medical Tourism Development in Guanacaste**

An answer to these questions may come with the realization of a large medical tourism undertaking in the Guanacaste region of the country on the Pacific coast, an area known for its beautiful beaches and tourism development. The Liberia airport, close to Guanacaste, recently expanded to accommodate more flights to this popular tourist area. Two of the “big three” private hospitals, CIMA and Clínica Bíblica plan to expand to open hospitals there, and the third, Hospital Hotel La Católica, intends to open a clinic in the region as well. Clínica Bíblica’s facility will be part of a large development project which includes hotels, a golf course, shops, restaurants and a retirement community for foreigners who would like to retire to Costa Rica, where their pensions will go further (Taborda 2011). Clínica Bíblica’s partner on this project is an American investor. Unlike the existing hospitals in San José, which attract Costa Ricans as well, the Guanacaste
facilities will cater almost exclusively to medical tourists and residents of the retirement community. Costa Rica is beginning to heavily promote itself as a place for elderly Americans to retire, which is increasingly becoming linked to medical tourism developments in the country. There has even been discussion around providing Medicare services for this population of American retirees. In addition to Guanacaste developments, since I completed this research, a new private hospital has opened in San José, and two more are scheduled to open by 2013. While there are many hopes and expectations for these multi-million dollar developments, there are also doubts among those working in the industry about whether “they will come.”

Some interview participants worry not about whether the Guanacaste development will be a profitable venture, but whether the project will worsen inequities in the area, and contribute to the development a "local-free" zone. Guanacaste has become a conspicuous example of highly inequitable tourism development in Costa Rica. The region, one of the poorest in the country, developed rapidly, without a clear plan for sustainability, and today is rife with disparities—golf courses sit next to local communities without access to clean water, all-inclusive resorts have risen in communities of primarily impoverished farmers who lack the education to work in these facilities, and tourism developments continue to exclude locals from access to private beaches and land.

These tourist facilities have virtually no relationship with the surrounding community in Guanacaste, and many are all-inclusive, which prohibits profits from benefitting local Guanacastecos. The result is that foreign owners "are importing people from other countries or from the metropolitan area” (NotiCen 2007) as locals are forced
into lower-paying jobs and the cost of living and real estate prices skyrocket because of tourism development. Mauricio Cespedes, executive director of the Guanacaste Tourism Chamber stated that "a social breach is opening ever wider between the average Guanacasteco and the people who come from San Jose"(NotiCen 2007).

**Medical Tourism and Inequities in Costa Rica**

Just as industry supporters argue for foreign investment as the major solution to poverty, the Costa Rican tourism industry stands as an example of this kind of investment working against the interests of the poor. The nation’s beaches and rainforests are becoming saturated with foreign-owned resorts, hotel chains, and American expatriate communities, but locals are left out of this process, and the resulting profits. An academic at the University of Costa Rica cautioned against further exacerbating such a situation with medical tourism, stating:

> My point is that we cannot open the issue of medical tourism if we’re not opening it with a vision that is regulated responsibly, with clearly defined policies, but also in a way that engages "production chains" that service communities, so that the situation that we’ve seen in Guanacaste is not repeated any more. I think it is a terrible lesson learned there, and yet it still continues to be repeated. (7)

The example of Guanacaste highlights the potential outcomes of inequitable tourism development that excludes locals, and draws monetary and human resources away from the local and poor, into the hands of the foreign and wealthy. Although medical tourism may still be too young as an industry to truly understand its impacts, this research illustrates the potential of the industry to contribute to unequal systems of health care and a widening gap in health care access, much like what has taken place in Guanacaste.
Financial Resources

Despite considerable concerns about the effects of medical tourism in Costa Rica, participants did acknowledge that there might be constructive ways in which the industry could impact local health systems, typically through economic development. At this point, however, these benefits seem to be little more than hypothetical; to date it is impossible to identify any direct benefit for the public health system. This is especially noteworthy since the Costa Rican government, the Caja, and universities, are all viewed as having a role to play in the promotion and support of the medical tourism industry (see Figures 13 and 14). The “Corporate Social Responsibility Fund” that Minister Woodbridge suggests will connect medical tourism to social health does not exist, and there are no plans for it to happen. Of the supposed benefits of medical tourism for the Costa Rican government, one physician said,

It’s usually a foreign person that comes in with the idea, pays the costs, and makes all the money. Some of them use the money here or live here, but some, like the hotel chains, well usually they take the money outside the country. Eighty-eight percent of the country’s hotel chains are not managed by nationals, they are all run by foreigners or multinationals. So, as a business, I think that the Costa Rican state and government are not going to make much money from medical tourism.

This is a business of only a few people, and the government is going to put the money in to make the rules, to promote it, but the money then just goes to the private clinics, who pay very little to the government. And the hospitals—well, CIMA hospital is not Costa Rican, it is American. La Católica is owned by a private group of the former president of the country, that is why all of this has been done—that is the reason why medical tourism was declared of national interest. It’s simply so the government can spend the money for these people to make even more money. La Bíblica is the only hospital that is Costa Rican, but it is also a foundation, so 45% of what they make, they invest back in themselves, and they don’t pay high taxes, so there is not much for the government to make from this. And they shouldn’t have the false illusions that there will be money for the state, because that will not happen. (32)
Medical tourism is not taxed differently than any other industry, though some thought that profits should be somehow redirected to the state, and that a special tax on medical tourism would be appropriate. One nurse feels that neglecting to redistribute the earnings from medical tourism goes against the social solidarity of the country and takes advantage of subsidized education. She said,

I think it [medical tourism] should have a tax, and if not a tax, well then a percentage of earnings should be designated for the national health system. There should be compensation in that respect, because, in the end, the doctors who are participating, they have been formed by the same government, the same country. In the public institutions, training a doctor or a nurse is not cheap, it requires investment; the country has invested in that human resource, and now that resource is looking to generate a higher position for themselves, without thinking about the rest of the people. (41)

Another interviewee, a Ministry of Health official, believed that there is a need for the government to take a stronger regulatory approach in dealing with medical tourism in order to maximize potential advantages and minimize harmful impacts:

I think that the government should regulate it [medical tourism] more… the government should have some part of what medical tourism generates, in terms of money and distribute it to the people who really need it… to put it into social programs that reduce inequity. The money should be distributed in a better way, but all the money is staying with the hospitals, and nobody is thinking about it. Or at least nobody in the government. Of course there is a lot of money involved here—it is a very good business and many people… Well it’s very nice for them to keep it quiet. To not do something with it. (13)

While the government and the Caja provide an unacknowledged subsidy of the medical tourism industry, the benefits they receive from the industry are virtually non-existent, and there are no plans to amend this. At best, public benefit from medical tourism will be distal, as profits (that are not redirected to foreigners) go to the Costa Rican elite, slowly making their way back to the public sector through general taxation and in-country spending.
**Internal Brain Drain**

In theory, the institutionalized public medical formation enables newly trained physicians to feed into the public system, where they remain for the duration of their careers caring for the Costa Rican population. In practice, many new physicians are beginning to split their time between the sectors, or practice exclusively in the private sector. This is due to increased privatization within Costa Rica, and challenges to the public system that make it undesirable for them to remain employed solely in the Caja. The phenomenon known as "internal brain drain," wherein physicians opt to practice in the more profitable private sector over the public sector, is of concern with regard to the continuing development of medical tourism in Costa Rica and the further divergence of public and private health care.

Particularly in certain specialties that are in demand in the private sector, the Caja has seen major shortages due to the number of physicians who break their contract and move into private practice, where they can make more money. The public subsidization of physicians who eventually end up practicing exclusively in the private sector is worrying, especially in a system that is already financially strained. Several participants expressed this concern. One Caja administrator who believes that medical tourism will impact the Caja through the loss of human resources stated, “the amount of professionals that are in the private sector are enough, that came from our [public] classrooms” (42). Another participant, an academic, expressed a similar frustration:

And on the subject of human resources in the health field, this is creating a big conflict, because with my taxes and all of us who pay taxes here in Costa Rica, we are paying for the training of medical specialists and many of these medical specialists are not even going to work in the public health system! They will work in the private system...
where wage standards are very, very different, than in the public health system... I mean, my colleagues have confessed to me and said, 'Look, I gave up working for the social security system because even when I had 25 years of working with the Caja and I was almost ready to retire, my salary did not exceed $2,500, so I prefer not to continue with this salary but instead to earn in private practice $20,000 per month.' This really changes things. (7)

In order to retain its physicians, the Caja must now compete with the private sector. This means that the public system, already so financially strained by the internal and external forces described in previous chapters, must somehow manage to raise the salaries of its employees in order to incentivize them to stay. This could lead to wage inflation, as has been the case in Thailand, where medical tourism has been indicted as a major contributor to a physician shortage (NaRanong and NaRanong 2011). As the government promotes Thailand as an international medical hub, local patients continue have poor access to quality health care, and public hospitals face a severe brain drain of health care workers who leave for the private sector. In 2005, the government of Thailand trained only 1,300 physicians, while 700 resigned during that same period—many to work in the private sector (Chambers 2011).

This internal brain drain seems to be occurring in Costa Rica as well. Medical tourism exacerbates human resource migration by offering new opportunities for physicians, increasing patient volumes within the private sector, and providing even higher remuneration than working with Costa Ricans in the private sector.

It is considered prestigious for physicians to work with medical tourists, because they tend to be the most educated, well-traveled, and skilled physicians. I asked in my interviews if there are specific requirements for physicians who work with medical tourists. The general consensus was that they had to speak English, have received some
training within the United States or Europe, and be certified within their specialty—but they also must be considered of high enough caliber. During an interview with one of the private hospital directors, he said,

R: There is a free market offer for physicians who want to work with medical tourists in my hospital. We establish some specific rules and standards, and then we evaluate whether they are what they think they are. They must inform us about their degrees, the courses they take, the congresses or seminars they go to. They must convince us that they are capable of working with medical tourists.

I: And are there many physicians who want to work more with medical tourists? Who want to go through this process of proving to you that they are capable?

R: Oh yes, yes, yes, of course. And sometimes, there are doctors that—well we are not so sure that we want them to work with medical tourists, so we kindly ask them not to. That is a privilege in the status of our doctors. (6)

The majority of physicians I interviewed work, or had worked, in both sectors, and many hoped to eventually move into the private sector exclusively, where they could earn more income, and have control over their time. The fact that the same physicians work in both the sectors, and can flow relatively freely between the two, makes it fairly easy for a Caja physician to leave for the private sector if patient volume is there—and medical tourism contributes to patient volume. Most who specialize in services that are in demand by medical tourists said that they would prefer to work with medical tourists, primarily for the salary boost. I asked an infectious disease specialist about the issue of internal brain drain, and he responded,

Yes, it has happened all ready. Many doctors have fled from the Caja to work in these specialties, and that is why we need so urgently, anesthesiologists and orthopedic surgeons…just one orthopedic surgery is extremely expensive. Several years ago I had a patient that had to undergo orthopedic surgery, and just with the surgery, not taking into account the whole set of days that she had to be inside the hospital, with just the surgery, the part of my bill was bigger than three complete months of full Caja salary. But by then, it was already too late for me [laughs], I was
already an infectious diseases specialist, I hadn’t thought of becoming an orthopedic surgeon at that point! (20)

Beyond the prestige of working with foreigners, physicians who worked with medical tourists often feel that they are freely practicing medicine because there are no constraints on them, like in the Caja. They have lots of time to spend with their patients, on training, and conducting research, and most importantly, did not feel financially constrained—they are able to perform whatever procedure they want, and use whatever medicines they want, regardless of the cost.

There is no limit to what these people will pay,” one surgeon told me. “Two weeks ago I had a patient here, an American, a very rich guy, and we found out that he needed a mediation—he needed two cc’s of a coagulant called Factor VII. And it’s $15,000 for each one. The guy said ‘don’t worry, bring it!’ It took one day. In the public sector that would never happen, and even in the private sector, the Costa Rican patient wouldn’t be able to afford that, so they would probably get sent to the Caja anyway. (28)

Practicing medicine in Costa Rica is becoming synonymous with advanced technology, medicines, and facilities and is transforming into treatment of fewer patients in a more specialized way. Treating medical tourists helps physicians feel that they have the freedom to practice unrestrained medicine, as opposed to working in the Caja, where they must work with limited resources.

The migration of physicians into the private sector, and into specialties that have more demand within the global marketplace further contributes to the shift away from care that is centered on preventive medicine, primary care, and local patients. A group of medical students I spoke with said that, just a few years ago, it was frowned upon to even consider specializing, and that the Caja encouraged all physicians to be “trained for cough, diarrhea and mucus…and that was the idea of our social system; our responsibility
as doctors. Now we are going into a different kind of medicine—we are medical scientists. We work based on evidence, we do complex surgeries, we want to know the last receptor in the brain that makes this medicine work” (43).

Costa Rican physicians are becoming more and more specialized, with some sub-specializing or even sub-sub-specializing. There is little incentive for these physicians to stay in the Caja, where physicians are paid based on seniority, and where mass care tends to be promoted over highly specific care. This has also been seen in Thailand, where doctors are now becoming so “super-specialized” that they no longer work in primary care at all.

As another aspect of internal brain drain, physicians are more frequently opting to remain in urban areas, particularly in and around San José, which concentrates health resources in these areas. The nation’s private hospitals are all currently located within San José only, so physicians who would like to practice in both sectors, or who desire to build a private practice gradually, must stay near the city to do so. This is likely one of the reasons why medical residents went on strike in 2010, objecting to their placements in rural areas.

Even though specialists tend to flee to the private sector, industry stakeholders maintained that it was the government’s responsibility to meet the industry’s need for specialists that medical tourism demands. One medical tourism promoter said, “the number of specialists we are going to need for this project is huge, so that is a big task that the government of the country has to face in order for medical tourism to be sustainable. Because if not, we cannot grow and we cannot fully receive foreign patients” (16). So, although the government does not benefit from the specialists whom they train,
and does not receive any direct profit from medical tourism, they are nonetheless considered responsible to invest in the training of health care personnel who work in the industry.

It seems, from this research, and case studies conducted elsewhere, that medical tourism does more harm than good to public health care provision. It siphons resources—monetary, human, and technological—from public to private, rural to urban, and general to specialized. It encourages a focus on procedures and areas of medicine that are in demand by the global market, and it contributes to a widening inequalities between public and private, rich and poor, foreign and local. The ways that this siphoning of resources contributes to an emerging dual track of medical care in Costa Rica will be discussed in the next chapter.
CHAPTER 7: MEDICAL TOURISM AND COSTA RICA’S CONTRADICTING VISIONS

This is a country that is privileged in terms of health care. That is the wonder of universal health care. Only a few countries, if not only in Costa Rica have a health system that is so good. The problem that we experience is from the ups and downs of the political and economical ideologies in the whole world that affect these kinds of systems.

Our government obeys international policies and bows to international economies that restrict these kinds of universal health systems, and in response, they deteriorate. But it is not because universal social security systems are bad—that is what they in world power try to tell us—that we should end universal social security because it is what is hurting economy, but it is not because of that. It is because of international pressures that demand that these types of systems stop existing.

So the system deteriorates and they want us to believe that it is deteriorating because the system itself is bad. But it’s not—it is a marvelous system. Hopefully the whole world would have a system built on solidarity like we do, because there are other countries where if you get sick, you will just die if you don’t have money.

— Caja nurse (44)

On-the-ground consequences of neoliberal reforms have been well documented, but there has been less attention to the impact that such reforms have on notions of health citizenship and social solidarity. Overarching the more tangible impacts that medical tourism has on the health care system, are the ethical and ideological implications that it has in a context such as Costa Rica. This chapter explores the juxtapositions that today exist in Costa Rica, taking as its primary focus the contradictory ideologies that give space for the emergence of medical tourism, an industry so seemingly at odds with principles of universal health coverage subsidized by the public sector, and the ways that this industry is changing how that Costa Ricans think about health care and state responsibility.

Costa Rica’s Contradictions

I am glad you chose Costa Rica, but I feel sorry for you, because we are complicated creatures. We are very, very contradictory. And we do
everything halfway until we get caught. And then we go at warp speed and we really exert ourselves and try to fix what has been done, but it is too late. That’s how it is, I am sure you find it very peculiar. (34)

The investigation of Costa Rican medical tourism reveals the contradictions of the current political and historical moment—a moment of systemic flux with regard to how the social contract between state and citizen is conceptualized. Costa Rica is a country that repeatedly rejects neoliberal principles in its health care system, yet adopts them in the signing of CAFTA; that resists privatization of the Caja, but provides unacknowledged subsidy of the private sector, and declares medical tourism—an industry fully entrenched in the private sector—an “activity of national interest.” Costa Rica is struggling to find its niche in the global economy, while at the same time fervently defending the social principles upon which it is founded.

**Medical Tourism and Opposing Ideological Values**

In discussing the medical tourism industry in this context, there are two polar conceptions of health systems at play here—socialized health care at one end, in which health is a social right and the state is the guarantor, and a neoliberal market system on the other, in which health is a commodity to be purchased. When the social mentality around health care that exists in Costa Rica is positioned alongside a model of private, for-profit health care, messages of social solidarity get convoluted. One public sector nurse summarized this point well, stating that it is not the financial or human resource impacts of medical tourism that concern her at present, but the incremental shifts in thinking that it represents:

I think that what is happening now with this type of tourism, is that it’s making the private sector grow. They are building hotels right next to these hospitals, or in the hospitals and…well, you can see the connection.
So the private hospitals are focusing on growth, but it is only for a certain group that has acquisitive capacity to do it, and has foreign capital.

In a certain way, I don’t know if I can say that it is all negative, but this brings changes to our culture. Because medical tourism, since it is for people with higher income, and above all for foreigners—it changes the idiosyncrasies, the individual character of our culture, as well as the determined spaces meant for certain sectors. It becomes more elite focused…and things happen that are for this other population, not for Costa Ricans. So there are cultural changes that also come with this process, and it is very important to take these into account. (41)

These incremental changes in Costa Rica are taking place much in the same way that privatization in general has been creeping in—there is little acknowledgement of what these changes mean within the state-dominated system. Although many Costa Ricans see themselves as against the neoliberal values that the United States represents, they do not always recognize the current changes that are occurring as part of the spread of those values. Rather, it is perceived as an accolade, proving that the developed countries of the world respect Costa Rica’s health system. It is seen as a way for Costa Rica to achieve national development and negotiate a place in the global economy. An internist whom I interviewed told me that medical tourism actually proved that Costa Rica was better than the United States, saying,

Actually, I like it [medical tourism]. You know why? Because there’s an idea that, in the States, they are the best. And actually, I have met a lot of Americans, and I have done surgeries on a lot of U.S. patients and I know that this isn’t true. You don’t get the best medicine in the States. So in opening this market, I think everybody will know that Costa Rica is really good—probably better than the United States. (10)

Medical tourism has become a new source of pride within Costa Rica, and a way for the world to recognize its accomplishments. This is paradoxical, in that the industry embodies principles of profit-driven health care that Costa Ricans loathe in the U.S.
system—which is seen as unfair, inefficient, and even inhumane, putting profits above the wellbeing of its citizens.

In addition to criticizing the U.S. system at large, Costa Rican physicians believe that American doctors are not truly free to practice medicine as it was intended, because of this model of health care as a business. “There are so many regulations in the United States,” a dermatologist told me, “You cannot, as a physician, be very free—you are bound by the insurance company, and what they will pay, or not pay. And so it’s not really your medical decision, the insurance company takes the decision from you. That’s not real medicine” (25). At the same time, however, CAFTA has opened up the private insurance market within Costa Rica, and there is a noteworthy trend towards privatization, as well as a growing inclination for physicians to move to the private sector, where they will likely face similar constraints on their practices as the private sector grows.

The demanding patients, and medico-legal climate of the United States is also cited as a difference from the Costa Rican system. One physician (who did recognize medical tourism as a different model of health care from social medicine) said that,

Medical tourism is a double-edged sword, because here we are used to a different kind of medicine. The United States are all protocols, informed consents, what is written down… it is just ‘take this’, ‘fill this’, if there’s any question: ‘read this.’ So it is very cold. I do not like that kind of medicine. It gives me a little bit of fear if a patient comes for medical tourism because in America they tend to demand everything. It rained, they claim it did not rain, so they sue [laughs]. But medical tourism has been inserted in Costa Rica with the same model of doctor-patient relationship as in the United States. So for me, it’s a shock, I do not know ... it’s the culture or something. (30)

It is well recognized within Costa Rica that the U.S. system is failing, and this is why medical tourists seek care outside of their borders. Yet, at the same time that Costa
Ricans boast about the foundations of their social system and critique the U.S. system, medical tourism is touted as a form of global prestige and a way forward for the country. Like the maintenance of the public-private divide, there is denial at work here, as Costa Ricans fail to acknowledge the interconnectedness between medical tourism and the neoliberal model of health care. This further exposes the social system to harm from outside and opens the door for a dual system of health care, as the cost, quality, and access to public and private health care provision continue to diverge.

**Competing Visions of Health Nationalism**

The popular Costa Rican notion of exceptionalism, rooted in the nation’s social past is now in competition with a very different vision of health nationalism based on caring for foreigners. Within this emerging vision of health care, the private sector is increasingly equated with wealth, efficiency, and a progressive, and nimble “way forward” for the country, while the Caja is viewed as an immovable, outdated symbol of Costa Rica’s past glory. These conflicting visions require a reworking of medicine, from a project of nation-making and social inclusion, to health care as commerce.

Last November, a visiting Latin American journalist, Andres Oppenheimer, gave a speech in San José in which he admonished Costa Rica for being “obsessed with the past, while other countries are looking towards the future” (Williams 2011). His talk was followed with an appeal by the president of the Costa Rican Medical Holding physician group, for the stronger promotion of medical tourism within the United States, as a means for economic development and “moving forward.” The rhetoric of medical tourism as progress for the nation is prevalent, especially among those with stakes in the industry.
Even a top-ranking Caja official told me that Costa Rica must “get on the train of change to move forward,” referring to the promotion of medical tourism (42).

Physicians are becoming more attracted to practicing medicine within the private sector, where they feel that they can locate the prestige and career advancement that they desire. They see the Caja as stifling this advancement through its focus on mass medicine and its promotion system based on seniority rather than skill or ambition. Increasingly, the Caja is being seen as preventing Costa Rica from moving forward, and is implicated in the current failures of the health care system, but excluded from its successes.

The purified “special” spaces that have been created within Costa Rica, described in the previous chapter, also embody the vision of Costa Rica’s global future, with their state-of-the-art technology, modern styling, and highly specialized physicians. The struggle over the future of the national health system in Costa Rica remains disconnected from these spaces, and from physician decisions to leave for the private sector.

Distinguishing Between Foreigners

Another interesting distinction that is made between the past and future visions of Costa Rica lies in the marked differences in opinions about Nicaraguan immigrants who use the health system versus medical tourists who use the health system.

While Nicaraguans are often seen as social pariahs, medical tourists and American expatriates or retirees are welcomed, and seen as a sign of global prestige. In the Costa Rican imagination, medical tourists are aligned with the future vision of the nation, while Nicaraguans represent the erosion of Costa Rican exceptionalism and a “return to Central America” (Ordoñez 2007 ). Participants in this research had almost
opposite feelings about these two groups of foreigners, and were clear to distinguish between them. In an interview, one physician stopped abruptly and said,

Maybe there is a need for differentiation—because a tourist that comes from the United States, to get surgery, he has it done in the private sector. He won’t go to the Caja to have the surgery, so he won’t be taking the place of a Costa Rican. That is fine. On the other hand, people who come from Nicaragua to work here in Costa Rica, they receive care in the Caja, so, in that case, it is a foreigner who is taking a Tico’s spot. (37)

Though there are other immigrant groups that enter the country to work, the number of Nicaraguans permanently living in Costa Rica has increased dramatically, making up about six percent of the current population (Muiser, et al. 2008). There are many more day laborers, who come into Costa Rica to work low level jobs, and then return to Nicaragua. Nicaraguans are the target of much anti-immigrant sentiment, and are often blamed for the current social ills of Costa Rica, such as reemerging infectious diseases, poverty, crime, prostitution, environmental degradation, and low wages.

The Caja is a site of significant anti-Nicaraguan sentiment, as immigrants are accused of using expensive care without contributing to the system. As opposed to medical tourists, who are seen as lifting the country out of poverty through economic development, Nicaraguans are equated with the deterioration of Costa Rica’s institutions, and are viewed as dirty, and as polluting the racial purity of the nation (see Chapter Two on the “white legend” of Costa Rica). I interviewed a female physician in the private sector who, when asked her opinion of the Costa Rican health system, responded,

I love it. Because if you are sick, you go to the hospital and you get what you need. The problem is immigrant people. Like for example, there was this Nicaraguan girl, she just crossed the border a week earlier and then she went into childbirth. So first, now we have now a new Costa Rican, and that population is getting bigger and bigger, and also, they didn’t pay any insurance, so that is the thing. And we Costa Ricans, we
pay, but with the money we spend, we are paying for immigrants. And I mean, it is expensive. (38)

When I asked this same physician whether Costa Ricans have any negative feelings about medical tourists using the Costa Rican system for care, she responded “Oh no, we like tourists! We have a saying here- ‘always smile to a tourist.’”

Medical tourists are positioned within the private—global—future vision of the country, while immigrants are positioned within the public—national—past, which is increasingly equated, too, with poverty and charity care.

**Medical Tourism Under a Social System**

While many Americans envision themselves as resisting the impersonal capitalist U.S. health care system by partaking in medical tourism, they are not outside of the neoliberal model of health care. By seeking care elsewhere, these tourists are, in fact, utilizing the individual responsibility and entrepreneurial spirit that the neoliberal system taught them.

Similarly, in Costa Rica, justifications for medical tourism often align with national discourse around social medicine. Though a powerful global economic model, neoliberalism is not always enacted in a uniform manner, or absorbed uncritically in destination countries. There are often local resistances that push back on global processes (Scott 1998), and globalization can be an inherently localizing process (Appadurai 1991). The way that Costa Rica “does” medical tourism in many ways is colored by their social past. Primarily, the rise of the Caja, its achievements, and its prominent role in Costa Rican national identity, have been effective in convincing Costa Ricans that health care is a basic human right.
The way that Costa Ricans rationalize medical tourism is indicative of this belief in social medicine. On numerous occasions, I was told that the benefits of medical tourism are not just in generating income for Costa Rica, but also that the industry is an opportunity for the U.S. health care system to be able to provide health care for all of their citizens. It is a chance for individual Americans to gain access to health care—as is their human right—when the United States fails to provide it for them. One physician said, “Medical tourism represents ethics and morals because we are giving Americans health care which they do not have at home” (35).

In the mind of many Costa Ricans, medical tourism takes on an altruistic form, compatible with social principles. Many justified privatization in the same way; in a conversation with three medical students at the University of Costa Rica, they thoughtfully told me,

A: Well privatization isn’t good if you do it everywhere, but I think that having private medicine and medical tourism can help the Caja… because the people who can pay will go to private hospitals, and this means that the people who really need the cheaper care will use it. Because if you can pay for private care, then pay your taxes and go to the private hospital, but don’t take the spots away from the people who cannot pay for private health care and are standing in line at the Caja. Some people would say that’s unfair… but that is how it should be, if you can pay, pay. The ones who cannot pay for it, they have no other choice. You have a choice.

B: Yeah, if you have the money, you can choose.

C: It’s a way for you to help someone who can’t. It is not just about paying taxes and putting the money into the system, it is about a whole way of thinking that we have-- to support each other, and the ones who can do some things [pay for private care], do them, so they will leave space for the ones who cannot take advantage of private care. For me that is why private expansion is okay, but you cannot lose that objective, that point of view. (43)
In her discussion of organ transplant tourism, Nancy Scheper-Hughes (2002) argues that capitalized economic relations that involve bodies are often masked in altruism. “In the new global economy,” she states, “the conflict between non-malfeasance (“do no harm”) and beneficence (the moral duty to perform good acts) is increasingly resolved in favor of the libertarian and consumer-oriented principle that those able to broker or buy a human organ should not be prevented from doing so” (2002). In these situations, an individual’s right to health trumps all other potential impacts and becomes the final word. In analyzing medical tourism, the rhetoric that highlights altruism and benevolence fits within a Costa Rican mentality of social solidarity and health as a human right. However, it can obscure the harmful impacts of this practice and further contribute to inequities in the medical system, which goes against these social principles.

**Medical Tourism, Distributive Justice and Moral Pluralism**

The employment of altruism as a justification for medical tourism not only masks its impacts, but masks moral pluralism and ethical implications, as medical tourists are often afforded different standards of care than locals. For example, in the Czech Republic, locals must be under the age of 38 to receive IVF treatments, while medical tourists must be under the age of 51 (Whittaker 2010a). In Cuba, a foreign passport is required to access well-stocked pharmacies, while locals are denied all but the most basic medications (Brotherton 2008). In Costa Rica, medical tourists utilize the special spaces of the private sector, while Costa Ricans must wait in line for care at the crowded public facilities. These are examples of “medical pluralism in motion,” within medical tourism destination countries (Pennings 2002), and illustrate post-colonial notions of the value of bodies, as bodies of the Third World are tasked with taking care of bodies of the First
World, which are seen as more deserving and in need. In many ways, the Costa Rican state is perpetuating the double moral that exists—by simultaneously promoting medical tourism, while at the same time struggling to care for its own citizens.

Some scholars, and participants in this research, feel that medical tourism is, at its core, an unethical or exploitive practice, in that it promotes taking advantage of lower health care costs in Costa Rica, rather than fixing the problems of the health systems from which medical tourists are coming, and takes away from care for locals. One participant, an academic, said:

I don’t like medical tourism. I don’t know; I don’t like it. Because I think it is making use of lower costs here than in the country where the people are from. I don’t know if that is fair… if you take resources away from Costa Ricans, then you are doing something wrong and you just do it because those people coming here can pay so much money… well, you know, they say that is economic development I guess. But I don’t think so. (22)

Some wondered whether medical tourism would lead to a dual-track health system, with the public sector caring for the poor majority, and the private sector caring for the Costa Rican elite and foreigners. There is evidence that medical tourism is contributing to such a split system in both Cuba and India.

In Cuba, where medical tourism is being promoted through the state, Brotherton (2005) has illustrated that a “medical apartheid” is occurring, wherein medical tourists access separate (public) facilities that require a foreign passport and foreign currency. These facilities are less crowded and better stocked with medicines than the ones that Cubans access. Hilda Molina, a physician, refused to comply with the government’s decision to turn her Neurological Center into a
tourist-only hospital, demanding that Cubans be treated equally, and was banned from practicing medicine (Vincent 2004).

In India, the private sector holds the large majority of physicians, technology and specialists (Thomas 2010) and only the very poor use public health care facilities. Seventy percent of health spending is private and out-of-pocket, while only four percent of government spending goes to health (World Health Organization 2000). Yet, the government heavily subsidizes the medical tourism industry and medical education, while the vast majority of Indians struggle to access to health care. For every 100,000 people, there are 60 physicians in India, compared with 279 in the United States (Meghani 2010). An outspoken critic of medical tourism stated that “every time a medical tourist comes to India, they are reducing the chances for an Indian to receive care” (Thomas 2010).

These case studies illustrate inequities produced by medical tourism, and some are concerned that if Costa Rica continues on its current trajectory, similar “dual track” health systems will result. However, because medical tourists are not using the Caja, which is where most Costa Ricans go for their care, this idea of “taking away from Costa Ricans” is not as obvious or direct, and many whom I spoke with did not feel that medical tourism detracts from local care. During one interview, just after discussing the role of the government in promoting medical tourism, creating regulations, and giving priority to training specialists that are in demand by the industry, I asked one medical director what the disadvantages of medical tourism might be for the country. He responded,
Disadvantages? No, in reality, I don’t see any. Because it is revenues that are not being taken away from anybody. The country has an infrastructure that is being underexploited, I mean here in this hospital, we have ten surgery rooms and at this very moment you can say to me that you want to operate on two patients and I would say yes (12).

This is related to the discussion of the public-private disconnect and the viewpoint that the public and private sectors do not share connected resources. In the case of Costa Rica, where the very physicians who tend to medical tourists are shared with the Caja, it is difficult to make this argument. Despite the denial by many participants that the public and private sectors share resources, there were some who I spoke with who did feel that medical tourism encouraged poor distributive justice, with the majority of the resources located in the wealthy private sector, while the poor get whatever remains. Meghani, who examined medical tourism from an ethical perspective, cited several ways in which medical tourism could be considered an unethical practice, stating, rather bluntly, that this practice is, in essence, “the have taking from the have nots” and an “agent of harm” (2010).

The idea of “excess capacity,” mentioned in the quote above, is prevalent within the private sector. This is an extreme contrast with the public sector, where facilities are always crowded with patients waiting to be seen; waitlists are sometimes over a year long, and physicians are required to see as many as 40 patients per day. Some medical tourism ads even draw on this false capacity within the private sector. One ad states,

Even though currently overburdened by needy citizens, the Costa Rican health care system is being utilized at less than 100%. The expensive medical equipment and high tech operating rooms stand idle every day after mid-afternoon. While wealthier Costa Ricans and some foreign residents make appointments with their private physicians, their numbers are not great enough to keep the private offices and clinics overly busy.
There is noticeable slack in the system, and it is this slack which serves the foreign tourist interested in the full spectrum of health care services offered (Underwood 2005).

This elucidates the neoliberal discourse around health care, wherein health is viewed as a commodity. The “slack in the system” means that there is more supply than demand in Costa Rica; they are seeking more clients. But there is plenty of demand for health care within Costa Rica. It just occurs in the public sector, because the majority of Costa Ricans cannot afford private care.

In a talk entitled “Medical Tourism in India: Private Profit, Public Pain,” an Indian physician, Dr. George Thomas (2010), spoke about this concept of “excess capacity” within the private sector, which Indian medical tourism facilities often use in their promotion of the industry. This capacity is false, he argues, because it arises out of the inability of local citizens to afford private health care. He equated this argument to saying “that there is an overabundance of food” simply because people cannot afford to buy food. This once again illustrates the divide between conceptions of health care as a commodity versus health care as a human right and social good. Medical tourists are being encouraged to receive health treatments that often times they do not need, meanwhile local populations struggle to access basic care.

**The Shifting Role of Social Responsibility**

Medical tourism indicates an erosion of social responsibility on which the Caja is founded. Physicians, who played such a prominent role in the national health system at the time of its development, are leaving for the private sector and avoiding any social responsibility to care for the Costa Rican population. Among some, social responsibility
has become more symbolic, volunteering a portion of their time to the Caja, or agreeing to take on Caja patients on occasion, as charity care. One plastic surgeon, who left the Caja to work with medical tourists, told me how he fulfilled his social responsibility as a Costa Rican physician, while practicing full-time in the private sector:

In my case, one of the most interesting surgeries that I was involved in at the Caja was breast reconstruction surgeries, so I decided to start my own private program for breast reconstruction here in my private practice, out of social commitment...When the program started, I did one surgery every four months, then I was able to do one every third month, then one every second month, then one every month, nowadays we are doing almost two every month, under the program. That is the way I keep the contact with the Caja population when I am here in private sector. (35)

While such initiatives are commendable, it is arguable that serving such a low number of poor patients could replace the social service of an entire career within the Caja. This limited charity work is hardly the vision of “physician as civil servant” that was intended when the Caja was founded.

This substitution of charity work for social responsibility has been discussed from an ethical perspective in India, where medical tourist hospital groups are initiating charity programs for the poor to “give back” to India. In that case as well, it is questionable whether the patients served on a charity basis can justify, not only the loss of public physicians, but also the money that the government spends promoting and subsidizing medical tourism to attract citizens of wealthier nations (Meghani 2010). A Caja nurse commented on the erosion of social responsibility, saying,

I think medical tourism would be fine, as long as the national health problems are getting solved, but the country has a pile of problems to be solved. And this is an industry where a lot of doctors are leaving to practice in the private sector, because they know that it means dollars. Truly, this ought to make us re-think whether, ethically and morally, this is what we were trained for-- for treating a population from another country and improving their conditions? I think it is difficult to say that
you are totally in favor of this. And the ethical and moral part of health professionals isn’t taken into account-- we give an oath to protect the life and health of the people who we attend to, and in reality we are going on a different path now…Maybe people do need private health care too, but not in the same way that they need the national health system. (41)

More than just individual physicians and nurses, there is an expectation that the private sector, as a larger entity, should give back to the public sector. There is nothing in place, to date, that ensures this will happen. Some do hope, however, that something like this will be instituted in a more formal way. One participant from the Caja talked about the role of the public and private sectors in health care provision, saying:

The role of the public sector is unquestionable attention to all citizens that are within our national territory. That means that the public health system has the obligation to protect the health of all the inhabitants of the country, whoever they are. This is for humanistic reasons, because we were formed in that mentality and that is the system that was taught to us since we were kids. So, of course, it is the Caja’s obligation to be the primary institution for all the health at a national level.

But I believe the private sector also has to give its contribution as part of society-- to contribute to the health system in some way. For example, maybe CIMA San José earns-- I don’t know how many hundreds of millions in surgeries from medical tourism-- well they should give a certain percentage to small consultations for preventive and community medicine for the community that is beside the hospital, I think that is a moral obligation of being part of the Costa Rican society. (44)

Costa Rica is home to a model of citizenship defined by socialist values in an economy increasingly defined by market-based reforms. Despite the contraction of the Caja, which has made it difficult to care for the Costa Rican population, there has been little change in the belief that health care is the responsibility of the state. Although the charity work suggested above is better than nothing, it is likely not enough to outweigh the harm to the Caja that the parasitic relationship with the private sector causes.
Regulating Medical Tourism

There is no regulation of this [medical tourism] in the country. Here in Costa Rica, we deal with things with tweezers. We are not explicit in saying look, look at what a shame this is, that this is happening, or calling attention to what isn’t working to try and fix it.

I remember one time that I was invited by the Municipality of San Jose and the Pan American Health Organization for a ceremony. It was for children protecting the environment. Medals were given, and there was food and a celebration. I stood up and said, ‘Look, I honestly feel very bad to be here, and I am sure that you won’t invite me again, but I need to tell you what I am feeling here. I am appalled that we reward children for picking up the garbage that adults throw away. It is a totally appalling cultural practice.’ I mean why are we to feel happy that children are protecting the environment that we are polluting as adults? Why is the attention not on the source of the problem? That is a story to illustrate how Costa Rica deals with things. We will not regulate medical tourism until it is too late. And even then we will just use some tweezers (7).

Medical tourism represents a new configuration of health care provision in a globalized world and there is currently a lack of consensus about whose responsibility it is to ensure that medical tourism is regulated in a socially responsible way. The growing standardization on the “sending” side of the medical tourism industry has not been matched in destination countries, making the industry subject to varying national regulations and costs.

Medical tourism brings up larger questions about who is to govern global industries. The industry has remained mostly unstructured in terms of governing legislation for medical tourism. It was clear from my interviews with those involved internationally felt that it was not the industry’s responsibility to regulate medical tourism in any way, but that it was the responsibility of governments in destination countries to ensure that any profits were redistributed fairly. In a published article in a medical tourism trade magazine, the president of the Medical Tourism Association wrote that she felt that governments in destination countries should reinvest their profits into further
infrastructure to accommodate increased patient flows from medical tourism. She went on in the article, to call the World Health Organization (WHO) and the World Trade Organization (WTO) “Big Brother Organizations,” asking, “Can you imagine the future of medical tourism held in the hands of the World Health Organization?” (Stephano 2009). This is clearly a distasteful proposition for stakeholders who prefer for the industry to avoid any international oversight that might quash profits. The question still remains, however, about whose responsibility it is to regulate medical tourism.

Meghani (2010), in her ethical assessment of medical tourism, finds that it is not a governmental issue, but rather an issue of individual ethics, and it is the traveling medical tourist him or herself who must refuse to partake in medical tourism, knowing that this practice causes harm to the health systems of destination countries. Dharamsi (2010) thinks, instead, that the lack of social accountability and moral core of the industry should be addressed through practicing physicians. He argues that physicians have a special professional status that requires that they be virtuous in their practice of medicine, particularly in cases where their medical education was paid for by the government.

A shift to neoliberal governmentality, in the case of medical tourism, prescribes national governance that is undermined by international laws and interests. This shift away from sovereignty leaves states weaker and with less power to enact policies that counteract global processes.

The governments of destination countries have lagged behind in developing regulatory frameworks that address the industry, and many of these countries are developing, and ill-prepared for the challenges that a global industry like medical tourism poses to their own health systems and legal regulations. In this case study of Costa Rica,
the private sector was seen as moving at a much faster pace than the Costa Rican
government, which did little to regulate the medical tourism industry beyond ensuring
that national standards for health facilities were complied with. The quote at the start of
this section illustrates the way that the Costa Rican government is perceived to deal with
its problems, using “tweezers” to make small corrections instead of getting to the root
cause.

As medical tourism expands rather rapidly in Costa Rica, it is likely that these
small corrections will come too late, after the industry has already done irreversible
damage to the public provision of health care. Instituting firmer regulation of the
industry, or formalizing pathways in which the private sector is required to give back to
the Caja may help to alleviate some of the burden, but given that the private sector’s
primary motivation is profit, it is unlikely that there will be substantial voluntary
contribution to the provision of public health care in Costa Rica. The popular belief that
that the private sector is not detracting from care within the Caja, further inhibits any
formal regulation in which the private sector would be obligated to contribute to public
health care.

Medical tourism is unlikely to disappear any time soon and, in all likelihood, will
continue to grow. Any regulation that at least attempts to maximize its benefits and
reduce its harms would be a step in the right direction. Market-based reforms in the form
of SAPs and Free Trade Agreements have already proven that they are destructive to the
social health care system of Costa Rica. Unregulated medical tourism alongside the
socialized system, especially as state-run industries are opened to the global market, has
the potential to be extremely detrimental to Costa Rica’s public system.
CONCLUSION

Medical tourism represents a new configuration of health care provision in a global world and has many potential implications for the way that health care is provided and conceptualized in destination countries. In thinking about medical tourism, it must be noted that this practice exists precisely because there are significant inequities between sending and receiving nations. Medical tourism occurs across lines of economic and social class divisions, and in fact depends upon these divisions—as well as entrenched inequalities within and between nations—for its prosperity. Rationalizations of medical tourism often ignore the power relations that make this industry possible. The political economy perspective used in this study helps to highlight these global connections and inequities and to draw attention to the contradictions that the industry represents.

At the moment, medical tourism is operated as a business, taking from the Costa Rican national health care system without giving to it. There is very little benefit to the public system, and in fact, there is real potential for harm. Beyond its ramifications in drawing resources away from public health care, it is also impacting the way that health care is conceptualized, as new ideological encounters around health and health care provision are initiated.

Recent anthropological work has promoted the development of an “anthropology of policy” (e.g Castro and Singer 2004; Horton and Lamphere 2006; Shore and Wright 1997) that encourages anthropologists to weigh in on public discourse surrounding pressing health and social issues. Beyond merely documenting the relationship between global and local configurations of health care, these perspectives challenge anthropology to be more involved in health policy issues that are too often relegated to a realm outside
of the discipline, where health economists hold hegemonic influence (Horton and Lamphere 2006). This research attempts to uncover the context of health policies that encase medical tourism; policies that “are shaped by a number of factors, only one of which, and sometimes the least of which is a concern with public health” (Castro and Singer 2004: xiii).”

In order to maximize the benefits and reduce the negative impacts of medical tourism, it is important to consider regulatory measures and oversight of the industry. These measures should ensure socially responsible practices that sustain the health care achievements that Costa Rica has made in the past century, rather than dismantle them. Examples of such regulation could include special taxation on medical tourism, channeling a percentage of profits directly into the public health sector, monitoring and regulating human resource needs and the ability of physicians to move freely between the two sectors, requiring the private sector to contribute to the training of physicians through the Caja, or utilizing private sector resources to ease the current burden on the public sector, which provides for Costa Ricans.

To this end, more critical attention is needed on the practice of medical tourism and the ways in which it interacts with and impacts existing health systems in destination countries. Particularly for underrepresented populations, social science research has an obligation to serve as a “counter-voice” to the hegemonic neoliberal discussions that are taking place around medical tourism in the developed world. Amidst all of the upbeat accounts of medical tourism in the media and praise for its possibilities, the potential harms are what need more research and attention. Powerful stakeholders in the industry have made their voice heard, but locals in destination countries have not yet had that
chance. Ethnographic perspectives are an important means to bring to light “local worlds” that are often overshadowed by powerful industries. This research is meant to be a step in this direction, voicing the concerns and experiences of local Costa Ricans to broaden understanding of the effects of medical tourism on local health systems and perceptions of health care.

Anthropology has an important role to play in generating detailed data from specific locales that can be used by program planners and policymakers as they design programs to take advantages of the benefits of medical travel and address the disadvantages created by this activity.
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APPENDIX A: EXAMPLE INTERVIEW GUIDE

Interview Guide for Physicians and Nurses

Thank you for agreeing to talk to me so that I can better understand what you and your clinic/hospital/company do, and a little more about medical tourism and how it operates here in Costa Rica, and your opinions about it.

This research is funded by the National Science Foundation of the United States, and the Wenner Gren Foundation. It is part of a dissertation project in Health and Behavioral Sciences and medical anthropology at the University of Colorado Denver. The goal of this research is to understand how medical tourism operates in Costa Rica, interaction between the medical tourism industry and the public health system and government in Costa Rica, opinions about medical tourism, and what impact, if any, it is having on the health system and access to health care in Costa Rica.

Your interview will be one of approximately 50-60 interviews. It will last up to an hour and be recorded. What you say will be kept anonymous, and your name as well as the name of your hospital, clinic, or company will not be used in the write-up of this research.

As we meet today, I have a range of questions I'd like to ask you about your experiences in the health care sector in Costa Rica, and your opinions and perceptions of the health system in Costa Rica and of medical tourism. If at any time you have questions please ask me, or if you want to stop for any reason please let me know.

Is it all right if I tape record this interview?

Employment and Background

• Can you tell me what your position is here at the hospital/clinic?
  • How long have you been working here?
  • How did you get involved with this work?
  • What is your employment background and education?
    • Have you worked in the public or private sector? Or both?
    • What is your medical specialization?

Knowledge of/Involvement with medical tourism:

• Do you have any involvement with medical tourism?

If no →

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26 In total, I used eight different interview guides depending on the participant’s position. This is an example of a guide that was used with physicians and nurses, translated into English.
- What do you know about medical tourism in general? In Costa Rica?
- What is your opinion of medical tourism?
- Would you want to be involved in medical tourism? Why/why not?

<table>
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| • What is your involvement with medical tourism in Costa Rica?  
  - How did you get involved? |
| • Do any medical tourists come here? If yes—  
  - How many?  
  - From where?  
  - For which procedures?  
  - Is there data collected?  
  - How do you attract medical tourists? |
| • What are the organizations that you work with regarding medical tourism here in Costa Rica?  
  - International organizations or associations (MTA)?  
  - Facilitator companies (specifically which ones)?  
  - Government organizations?  
  - Insurance companies?  
  - Any others? |
| • What is the relationship between your hospital/clinic and these organizations? |
| • Do physicians need any special skills or training to work with medical tourists? |
| • Do doctors who work in medical tourism need malpractice insurance? |

**General information about hospital/clinic:**
- What kind of patients utilize your office/hospital the most? (A general profile)  
  - If foreign, where do they come from? |
- What are the most common procedures or surgeries patients receive here? |
- Is this data collected? |

**Relationship between Public and Private Sector**
- Why did you choose to practice in the public/private sector?
• What do you think the general differences are for a physician working in the public versus the private sector?
  • Salary differences?
  • Employment benefits?
  • Patient volume (how many patients they treat)?
  • Working environment (better technology? Nicer facilities? Calmer environment?)
  • Quality of care?
  • Prestige-- which one is considered more prestigious? Why?
• Do you have an idea of what the salary range of physicians in the private versus the public sector?
• As a physician, do you think it more attractive to practice in the public or private sector? Why?
• What about physicians who treat medical tourists? What are the advantages/disadvantages?
• Do you think there is sufficient motivation for physicians to practice in the public sector?

The Health System in Costa Rica:
• What is your general opinion of the health care system here in Costa Rica?
• What do you think are the most positive and negative aspects of the Costa Rican health care system?
• Do you use the public or private health sector for your health care? Why?
• Have you had any particularly positive or negative personal experiences with health care in Costa Rica that you can tell me about?
• What do you think the roles and responsibilities of the public and private health care sectors are? How are they different?
• Do you think that private hospitals and clinics should promote medical tourism? Why or why not?
• In what ways do you think the government is involved in medical tourism?
  • In what ways do you think the government should be involved?
  • Do you think that the government should promote medical tourism? Why or why not?
• What do you think a government’s responsibility is with regard to health care for its citizens? What is the role of the private sector?
Do you think that private health care and medical tourism, as economic activities, fit with the health care ideology in Costa Rica and Caja’s principles of universality, solidarity & equity?

**Impact of Medical Tourism**

- Where do you think the profits from medical tourism go? Where should they go?

- In general, what do you think the advantages or benefits of medical tourism are for Costa Rica?
  - Are there any direct benefits to the health care system?
  - Probes → Arguments about how it *could* have positive impact:
    - Increased national tourism revenue?
    - Improvements to infrastructure?
    - Physician training?
    - New technologies?
    - Better standards of care?
    - New physician specialties?
    - Keeping physicians in Costa Rica?

- In general, what are the disadvantages or negative effects of medical tourism?

- Do you think focusing on medical tourism in Costa Rica has any negative impact on the public health care for Costa Ricans?
  - Probes → Arguments about how it *could* have negative impact:
    - Is it causing physicians to specialize in things that are not important for local populations? (i.e. plastic surgery/weight loss surgeries)
    - Is it drawing attention away from primary health care to more specialized procedures?
    - Is it drawing physicians out of the public sector?
    - Is it creating a split health care system where the wealthy and foreigners get one kind of care and other Costa Ricans another?

**Future:**

- What do you think the future of medical tourism will be here in Costa Rica? Do you think it will continue to grow?

- What do you think the focus of the Costa Rican health system should be moving into the future? (i.e., should there be a focus on primary care or on new health technologies and tertiary care?)

- Is there anything else that we did not ask that you would like to add? Any additional comments?

***THANK YOU FOR PARTICIPATING***
Follow-Up:
- Do they know anyone else we could contact for an interview?
- Do they know of any data that is available in Costa Rica on medical tourism?
- Is there any data available at their hospital/clinic we could look at?
  - Numbers of patients, procedures they come for, demographics (age, where they are from, etc.), physician specialties and procedures performed? Where revenues go?
- Possible to tour facility?
- Can we distribute surveys to patients at their facility?
APPENDIX B: SURVEY GUIDE

Buenos días/Buenas tardes

Mi nombre es Courtney Lee, soy de la Universidad de Colorado. Estoy aplicando unos cuestionarios con respecto a sus opiniones sobre el sistema costarricense de salud. Mi asistente está conmigo, ella se llama Silvia Romero y es de la Universidad de Costa Rica. Solicitamos el permiso al Hospital o la clínica para hacer este trabajo. Ninguna respuesta es correcta o incorrecta y es absolutamente confidencial.

Encuesta

1. Profesión/trabajo: 
2. Área donde vive: 
3. Salario mensual (aproximado): 
   - Menos de 150.000 colones por mes
   - Entre 150.000 y 250.000 colones por mes
   - Entre 250.000 y 500.000 colones por mes
   - Entre 500.000 y 750.000 colones por mes
   - Más de 750.000 colones por mes

   Cualquier comentario:

SISTEMA DE SALUD COSTARRICENSE

4. ¿En general, cuál es su opinión del sistema de salud en Costa Rica? Tomando en cuenta tanto el sector público como el privado.
   - Excelente, no necesita ningún cambio
   - Muy bueno
   - Bueno
   - Promedio, necesita algunas mejoras
   - Muy malo, necesita muchas mejoras

   Cualquier comentario:

5. ¿En un año, qué tanto usa los servicios de La Caja?
   - Más de 20 veces por año
   - 16-20 veces por año
   - 11-15 veces por año
   - 6-10 veces por año
   - Menos de 5 veces por año
Cualquier comentario:

6. ¿Qué tanto usa los servicios de salud privados o particulares?
☐ Más de 20 veces por año ☐ 6-10 veces por año
☐ 16-20 veces por año ☐ Menos de 5 veces por año
☐ 11-15 veces por año

Cualquier comentario:

7. ¿Cuándo usa los servicios de La Caja y cuándo usa los servicios privados y por qué?

Cualquier comentario:

8. ¿Cuál es su opinión de los servicios de La Caja en las siguientes áreas?

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<thead>
<tr>
<th></th>
<th>Excelente</th>
<th>Muy bien</th>
<th>Bien</th>
<th>Promedio</th>
<th>Debajo de promedio</th>
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Cualquier comentario:
9. ¿Cuál es su opinión de los servicios privados o particulares en las siguientes áreas?

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</table>

Cualquier comentario:

10. ¿Cuáles considera que son los aspectos más positivos de La Caja para Costa Rica?

________________________________________________________________________

________________________________________________________________________

11. ¿Cuáles considera que son los aspectos más negativos de La Caja para Costa Rica?

________________________________________________________________________

________________________________________________________________________

12. ¿Cuáles considera que son los beneficios del desarrollo de la medicina privada para Costa Rica?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
13. ¿Cuáles considera que son las desventajas del desarrollo de la medicina privada para Costa Rica?

____________________________________________________________________________________________

14. ¿Quién es más responsable con respecto a la salud de los costarricenses?
   [ ] La Caja  [ ] El sector privado  [ ] Ambos, igualmente
   [ ] Personas individuales  [ ] Otro: ___________________________

15. ¿Cree usted que Costa Rica debe dar atención médica a los turistas médicos que vienen a Costa Rica para recibir atención médica?
   [ ] Sí  [ ] No  [ ] No sé

   Cualquier comentario:

16. ¿Cuáles son las ventajas o beneficios del turismo médico para Costa Rica?

____________________________________________________________________________________________

____________________________________________________________________________________________

17. ¿Cuáles son las desventajas o impactos negativos del turismo médico para Costa Rica?

____________________________________________________________________________________________

____________________________________________________________________________________________

¿Muchas gracias!
### APPENDIX C: PARTICIPANT LIST

<table>
<thead>
<tr>
<th>Transcript #</th>
<th>Participant Description</th>
<th>Location of Interview</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Administrator of a medical tourism association</td>
<td>United States (phone)</td>
</tr>
<tr>
<td>2</td>
<td>Administrator of a medical tourism association</td>
<td>United States (phone)</td>
</tr>
<tr>
<td>3</td>
<td>Regional coordinator of a medical tourism association</td>
<td>San José, Costa Rica</td>
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<tr>
<td>4</td>
<td>Medical tourism facilitator</td>
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<tr>
<td>5</td>
<td>Academic</td>
<td>San José, Costa Rica</td>
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<tr>
<td>6</td>
<td>Private hospital administrator</td>
<td>San José, Costa Rica</td>
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<tr>
<td>7</td>
<td>Caja physician and academic</td>
<td>San José, Costa Rica</td>
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<tr>
<td>8</td>
<td>Caja ex-administrator and physician</td>
<td>San José, Costa Rica</td>
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<td>9</td>
<td>Private sector physician</td>
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<td>10</td>
<td>Private sector physician</td>
<td>San José, Costa Rica</td>
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<td>11</td>
<td>Ministry of Health official</td>
<td>San José, Costa Rica</td>
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<td>12</td>
<td>Private hospital administrator</td>
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<tr>
<td>13</td>
<td>Ministry of Health official</td>
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<tr>
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<td>San José, Costa Rica</td>
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<td>15</td>
<td>Private sector physician</td>
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<td>16</td>
<td>Ministry of Competitiveness official</td>
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<td>17</td>
<td>Private hospital ex-administrator</td>
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<td>18</td>
<td>Private hospital administrator</td>
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<tr>
<td>19</td>
<td>Private sector physician (assistant was present as well)</td>
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<tr>
<td>20</td>
<td>Caja and private sector physician</td>
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<tr>
<td>21</td>
<td>Private sector physician</td>
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<td>Caja physician</td>
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<td>Pan American Health Organization official</td>
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<td>25</td>
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<td>26</td>
<td>Caja and private sector physician</td>
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<td>27</td>
<td>PROCOMER (Foreign Trade Agency) official</td>
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<td>Caja and private sector physician</td>
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<td>Private sector physician</td>
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<td>Medical tourism facilitator and private sector physician</td>
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<td>36</td>
<td>Medical resident and Caja physician</td>
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<td>37</td>
<td>Group interview with 3 medical residents/Caja physicians</td>
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<td>38</td>
<td>Caja and private sector physician</td>
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<td>Academic</td>
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<td>Private hospital administrator</td>
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<td>41</td>
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<td>42</td>
<td>Caja hospital administrator and physician</td>
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<td>43</td>
<td>Group interview with 3 medical students</td>
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<td>45</td>
<td>Caja hospital administrator and physician</td>
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<td>46</td>
<td>Caja physician</td>
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<td>47</td>
<td>Caja physician at a Cooperative</td>
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<tr>
<td>48</td>
<td>Medical tourism researcher and academic</td>
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**Transcript #37 and #43 each had three participants, and one was present at both interviews. Transcript #14 was of a follow-up interview with the same participant as #4. Removing duplicate participants and adding the additional participants from the group interviews, the total participant number is 50.**